

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: Male Female Undifferentiated Decline to Specify

Glasses/Contact Lenses (Please check appropriate boxes below)

Do you currently wear glasses? No Yes If yes, how old are your glasses? _____ Type? _____
 Do you currently wear contact lenses? No Yes If yes, for how long? _____ Type? _____
 Have you ever tried contact lenses? No Yes When did you last wear contacts? _____

Allergies (Meds/Latex/Anesthesia): No Yes If yes, which ones: _____

Current Medical Problems: HTN (High Blood Pressure) Elevated Lipids (High Cholesterol) Diabetes Type I Diabetes Type II Sjogren's
 Rheumatoid Arthritis Other: _____

*If applicable, are you currently or possibly pregnant? No Yes | *If applicable, are you currently breastfeeding? No Yes

Previous Surgeries: _____

Family History (M-Mother, F-Father, S-Sister, B-Brother, MGM/MGF-Maternal Grandmother/Father, PGM/PGF-Paternal Grandmother/Grandfather)

Glaucoma _____ Diabetes _____ Cancer _____ HTN (High Blood Pressure) _____ Keratoconus _____
 Retinal Detachment _____ Color Blindness _____ Macular Degeneration _____ Other _____

Social History (Please check and/or circle appropriate boxes below)

Do you drive? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you smoke tobacco? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, how often? _____
Do you drink caffeine? <input type="checkbox"/> No <input type="checkbox"/> Yes	Do you currently vape? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, with/without Nicotine? _____
If Yes, type & amount? _____	If Yes, have you ever tried to quit? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you drink alcohol? <input type="checkbox"/> No <input type="checkbox"/> Yes	If Yes, when or how long ago? _____
If Yes, amount & how often? _____	Have you had passive smoke and/or vaping exposure? <input type="checkbox"/> No <input type="checkbox"/> Yes

Current Medications:

*Include over-the-counter No Yes _____

Review of Systems: Do you currently have any of the following symptoms? (Please check the appropriate boxes below)

Environmental Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes	Polydipsia (Excessive Thirst) <input type="checkbox"/> No <input type="checkbox"/> Yes	Rash <input type="checkbox"/> No <input type="checkbox"/> Yes
Food Allergies <input type="checkbox"/> No <input type="checkbox"/> Yes	Polyphagia (Excessive Hunger) <input type="checkbox"/> No <input type="checkbox"/> Yes	Arthralgia (Joint Pain) <input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Pressure <input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Loss <input type="checkbox"/> No <input type="checkbox"/> Yes	Joint Swelling <input type="checkbox"/> No <input type="checkbox"/> Yes
Chest Discomfort <input type="checkbox"/> No <input type="checkbox"/> Yes	Constipation <input type="checkbox"/> No <input type="checkbox"/> Yes	Muscle Weakness <input type="checkbox"/> No <input type="checkbox"/> Yes
Irregular Heartbeat <input type="checkbox"/> No <input type="checkbox"/> Yes	Diarrhea <input type="checkbox"/> No <input type="checkbox"/> Yes	Dizziness <input type="checkbox"/> No <input type="checkbox"/> Yes
Heart Palpitations <input type="checkbox"/> No <input type="checkbox"/> Yes	Vomiting <input type="checkbox"/> No <input type="checkbox"/> Yes	Gait Disturbances <input type="checkbox"/> No <input type="checkbox"/> Yes
Fatigue <input type="checkbox"/> No <input type="checkbox"/> Yes	Dysuria (Painful Urination) <input type="checkbox"/> No <input type="checkbox"/> Yes	Headache <input type="checkbox"/> No <input type="checkbox"/> Yes
Fever <input type="checkbox"/> No <input type="checkbox"/> Yes	Hematuria (Blood in Urine) <input type="checkbox"/> No <input type="checkbox"/> Yes	Emotional changes <input type="checkbox"/> No <input type="checkbox"/> Yes
Night Sweats <input type="checkbox"/> No <input type="checkbox"/> Yes	Polyuria (Excessive Urination) <input type="checkbox"/> No <input type="checkbox"/> Yes	Cough <input type="checkbox"/> No <input type="checkbox"/> Yes
Cold Intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes	Bruising <input type="checkbox"/> No <input type="checkbox"/> Yes	Wheezing <input type="checkbox"/> No <input type="checkbox"/> Yes
Heat Intolerance <input type="checkbox"/> No <input type="checkbox"/> Yes	Easy Bleeding <input type="checkbox"/> No <input type="checkbox"/> Yes	Other: _____

Eye History: Have you ever had or been told you have: (Please check appropriate boxes below)

<input type="checkbox"/> Cataracts	<input type="checkbox"/> Cataract Surgery	<input type="checkbox"/> Herpes Infection of the Eye	<input type="checkbox"/> Foreign Body Sensation
<input type="checkbox"/> Glaucoma (High Eye Pressure)	<input type="checkbox"/> Laser Eye Surgery	<input type="checkbox"/> Recurrent Corneal Erosion	<input type="checkbox"/> Irritation or Dryness
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Pterygium Surgery	<input type="checkbox"/> Blurred or Double Vision	<input type="checkbox"/> Excessive Tearing or Watering
<input type="checkbox"/> Diabetic Retinopathy	<input type="checkbox"/> Corneal Surgery	<input type="checkbox"/> Glare/ Light Sensitivity	<input type="checkbox"/> Mucous Discharge
<input type="checkbox"/> Flashes or Floaters	<input type="checkbox"/> Eyelid Surgery	<input type="checkbox"/> Distorted Vision / Halos	<input type="checkbox"/> Redness
<input type="checkbox"/> Retinal Tear/Detachment	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Loss of Vision	<input type="checkbox"/> Drooping Eyelids
<input type="checkbox"/> Keratoconus	<input type="checkbox"/> Amblyopia (Crossed/Lazy Eye)	<input type="checkbox"/> Eye Pain or Soreness	<input type="checkbox"/> Other: _____

I understand that dilating eye drops may be used in my examination and may blur my vision, making it unsafe to drive. I will not attempt to drive until I am certain the effect of the medicine has worn off. The effect of the drops may last an hour or longer.

My signature below indicates that the information provided above is accurate and complete to the best of my ability.

Signature of patient (if over 18) or patient's parent or legal guardian _____

Date _____

If signed by parent/legal guardian, print name _____

Relationship _____