TODAY'S DATE: _____ CHART ID: _____ Page 1 of _____

NAME: _____ HEIGHT: _____ WEIGHT: _____ Referring Dr: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ RACE: _____ Primary Care Dr: _____

Are you a new patient? **Y** or **N** (Please circle response)

If "No", has your medical history changed since your last visit? **Y** or **N** ? Date of last eye exam: _____ Dr: _____

List any surgeries you have had (Cataract, Tonsils, Appendix, etc.):

_____

_____

_____

_____

SOCIAL HISTORY:

Are You: Single Married Widowed Divorced

Employed Retired Other: _____

Occupation: _____

Smoking Status: Current Former Never E-cigarette / Vape

Drink alcohol? **Y** or **N**

Drinks per day or week? _____

Do you currently have any problems in the following areas?
If "Yes", Please provide information.

1. General (Fever, Weight Loss, etc.)
2. Ear, Nose, Throat (Sinus, Dry Mouth, etc.)
3. Cardiovascular (Heart, Stroke, Blood Pressure, CAD, CHF, etc.)
4. Respiratory (Asthma, Bronchitis, COPD, etc.)
5. Gastrointestinal (Stomach Ulcers,GERD, etc.)
6. Genital, Kidneys, Bladder (Prostate, Incontinence, etc.)
7. Muscles, Bones, Joints (Arthritis, Osteoporosis, etc.)
8. Skin (Warts, Acne, Cancer, etc.)
9. Neurological (Multiple Sclerosis, Tumor, etc.)
10. Psychiatric (Anxiety, Depression, Insomnia, etc.)
11. Endocrine (Diabetes, Thyroid Dysfunction, etc.)
12. Blood / Lymph (High Cholesterol, Anemia, Hep C, HIV/AIDS, etc.)
13. Allergy / Immunologic (Hay Fever, Lupus, Rheumatoid, etc.)

Explanation of Problem: _____

_____

_____

_____

_____

_____

_____

_____

FAMILY HISTORY:
Does anyone in your immediate family have any of the following?
(Circle all that apply and list family member)

Blindness	High Blood Pressure
Glaucoma	Kidney Disease
Arthritis	Lupus
Cancer	Stroke
Diabetes	Thyroid Disease
Heart Disease	Other: _____

Explanation of Problem: _____

_____

_____

_____

Ocular History (Circle all that apply):

Cataract Trauma Glaucoma Macular Degeneration

Lazy Eye Diabetic Retinal Changes Dry Eye Syndrome

Contact Lens Wearer Previous Eye Surgery

Are you a Diabetic?

How long have you been Diabetic? _____

Last HbA1C: _____

Last Blood Sugar: _____

What Pharmacy do you use? (Name and Address)

Local: _____

Mail-Order: _____

Have you ever taken Flomax or Tamsulosin? **Y** or **N**

Are you post-menopausal? **Y** or **N**

If not: Is there any chance you could be pregnant? **Y** or **N**

Have you had your Influenza Vaccine (Flu shot)? **Y** or **N**

Have you had your Pneumonia Vaccine? **Y** or **N**

Have you had any falls in the past year? **Y** or **N**

If yes, any injuries sustained from the fall? **Y** or **N**

Brief Description of your eye problem, and if it is getting worse, better, or fluctuates: _____

_____

_____

_____