Patient Name: Date of Birth: Account: Date:

What brings you in today?

When was your last eye exam

Do wear glasses, contact lenses or both?

Were you Referred? By:

Do you have a history of:	Yes	No	**Do you currently have any problems with:**	Yes	No
Double Vision			Chest pain, heart racing, shortness of breath		
Decreased vision			Hearing loss, Dizziness, ringing in ears		
Eye Pain			Back, muscle, joint pain; swelling, stiffness		
Floaters in your Vision			Cough, trouble breathing, wheezing		
Flashing lights			Fatigue, fever, weight loss, weakness		
Eye Injury			Easy bleeding or bruising, tender nodes		
Serious eye infections			Balance problems, numbness, tingling, headache		
Eyelid problems			Hair loss, rashes, skin lesions		
Abnormal pupil			Painful urination, frequency		
Cornea disease			Excessive heat/cold intolerance; increased hunger or thirst, frequent urination		
Glaucoma			Anxiety, depression, irritability, insomnia, nervousness		
Cataract			Seasonal allergies, chronic runny nose, itching		
Retina disorder					
Eye tumor			Do you smoke?		
Eye(s) turning in or out			Have you ever smoked for 1 year or more?		
			Do you drink alcohol?		
Do you use any Eye Drops? Please list and how you use			Have you had a flu shot in the last year?(88)		
			Have you had a pneumonia shot?(109)		
			Have you had a shingles shot?(121)		
			Have you had a fall in the last year?		
			Are you HIV positive?		
Allergy to eye drops (list)			**Have You Had any Eye Surgeries? Please list Surgeon**	**When? (approx.)**	
Have you had any Surgeries?	When? (approx.)		**Do you have any Family history of: Parents, siblings, grandparents, children**	**Yes**	**No**

Patient Name: Date of Birth: Account: Date:

		Cataracts		
		Glaucoma		
		Macular Degeneration		
		Blindness (any cause)		
		Lazy Eye, Strabismus		
		Cancer: type		
		High Blood Pressure/heart disease		
		Diabetes, Type 1 or Type 2		

Please list Medications taken	Dosage	When?	Why do you Take it?

	Yes	No			
Are you allergic to Penicillin?			If yes, reaction:		
Are you allergic to Latex?			If yes, reaction:		
Are you allergic to Betadine?			If yes, reaction:		
Are you allergic to any other medications?			List:		

Comments?

Doctor's signature:_____Date:_____