Name:	Birth date:	Today's Date:
Primary Care Physician:		Referring Physician:

Please check the Yes (Y) box ONLY if you have ever been diagnosed with the following. If not, leave box unmarked:

Endocrine	Y
Diabetes	
Year Diagnosed:_____________	
Treating Physician: _______________	
Thyroid Problem	
Pituitary Problem	
Pulmonary	**Y**
Breathing Problems	
Asthma/Emphysema/COPD	
Sleep Apnea	
List other:_______________	
Cardiovascular	**Y**
Arrhythmias	
Carotid Artery Blockage	
Heart Attack	
High Blood Pressure	
High Cholesterol	
Pacemaker	
List other:________________	
Gastroenterology	**Y**
Crohn's Disease	
Irritable Bowel/Colitis	
Stomach Ulcer	
Hematologic	**Y**
Bleeding Problems	
Clotting Problems	
Head and Neck	**Y**
Allergies- Hayfever, Mold	
Hearing Impaired	
Sinus Congestion	
Renal/Reproductive	**Y**
Renal Failure/Dialysis	
Sexual Transmitted Disease	
Prostate Problem	
Pregnant or Nursing?	

Immunology	Y
Cold Sores	
Hepatitis	
HIV/AIDS	
Lupus	
Sjorgren's	
Sarcoidosis	
Temporal Arteritis/Giant Cell	
Neurology	**Y**
Alzheimers/Dementia	
Headaches/Migraines	
Multiple Sclerosis	
Parkinson's	
Seizure Disorder	
Stroke	
Skin/Muscular/Skeletal	**Y**
Acne Rosacea	
Dermatitis/Eczema/Psoriasis	
Fibromyalgia	
Rheumatoid Arthritis	
Scleroderma	
Emotional/Developmental	**Y**
Anxiety	
Depression	
Bipolar	
Schizophrenia	
Attention Deficit / Hyperactive	
Intellectual Developmental Disability (MRDD)	
Learning Disability	
Autism	
Social History:	
Your Occupation:	
Circle: Married Single Divorced Widowed Live Alone	
Do you still drive?	

Drug Allergies - if yes: list	

List any Medications

Do you take Eye Medications?	Y

List: Vitamins, Tears, and Eye Drops

List any non-eye surgeries	Year

Cancer: List Type & Year	

Have you EVER taken	Y
Flomax (Tamsulosin)	
Hytrin (Terazosin)	

Do you take? (please circle)

Aspirin **Coumadin** **Plaquenil** **Plavix** **Prednisone**

Do you use?

Alcohol? If yes, how much per wk? ___________________________		Tobacco? If yes, how much? Or when did you quit? ________________________		Recreational Drugs? If yes, what and how often? ________________	

Please check the Yes (Y) box if it applies.

Eye Health	Y
Dry Eye	
Serious Eye Injury	
Crossed Eyed/Lazy Eye	
Double Vision	
Chronic Tearing	
Eye Lid Crusting/Blepharitis	
Macular Degeneration	
Retina Problem (other)	
Flashes/Floaters	
Glaucoma	
Cold Sore in or near the eye	
Shingles near the eye	
Iritis / Uveitis / Inflammation	
Corneal disease or surgery	
Other:	
Cataract Surgery	Y
If yes; When:____________ Which Eye: Right Left Both Name of Surgeon:_______________________________	
Follow up Laser?	**Y**
Lasik /PRK / RK (Please Circle)	
If yes; When:__________ Name of Surgeon/location:___________________	
Other Laser Surgery	**Y**
Retina	
Glaucoma	

Glasses	
Do you wear glasses? Circle: All the time ; Distance only ; Reading only How old are your glasses: ___________	
Where did you purchase your glasses: ______________________________	
Are you happy with your current glasses?	

Family Eye History – please list who	Y
Blindness:	
Corneal Problem:	
Glaucoma:	
Lazy/Crossed Eye:	
Keratoconus:	
Macular Degeneration:	
Retinal Problems:	
Other:	
Other:	

Contacts	Y
Do you wear contacts? (Circle) Gas Permeable? Monovision? Bifocal? For Astigmatism?	
Do you know the brand of contacts you wear? Name: _______________________	
On average, how many hours per day do You wear them? _____	
How often do you replace your lenses? _____________	
What brand solution do you use? ______________________ Are you happy with your current contacts?	

Office Use Only	
Physician & Technician Review	Date
Provider Signature:	