Name _____

PLEASE FILL OUT ENTIRE PAGE COMPLETELY

Eyes

Previous Surgery	☐ Yes	☐ No
Contact Lens	☐ Yes	☐ No
Pain	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No
Macular Degeneration	☐ Yes	☐ No
Dry Eyes	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Watery eyes	☐ Yes	☐ No
Tired eyes	☐ Yes	☐ No

Ears, Nose & Throat

Hard of Hearing	☐ Yes	☐ No
Ringing in Ears	☐ Yes	☐ No
Vertigo	☐ Yes	☐ No

Cardiovascular

Chest Pain	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No
Fainting Spells	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No
Difficulty Lying Flat	☐ Yes	☐ No

Constitutional

Fatigue/Weakness	☐ Yes	☐ No
Fever	☐ Yes	☐ No
Weight Gain/Loss	☐ Yes	☐ No
Fall Risk	☐ Yes	☐ No

Respiratory

Cough	☐ Yes	☐ No
Congestion	☐ Yes	☐ No
Wheezing	☐ Yes	☐ No
Asthma	☐ Yes	☐ No

Gastrontestinal

Heartburn	☐ Yes	☐ No
Nausea/Vomiting	☐ Yes	☐ No
Jaundice/Hepatitis	☐ Yes	☐ No

Genito-Urinary

Pain/Difficulty	☐ Yes	☐ No
Blood in Urine	☐ Yes	☐ No
History of Kidney Stones	☐ Yes	☐ No
History of STD's	☐ Yes	☐ No

Psychiatric

Anxiety/Depression	☐ Yes	☐ No
Mood Swings	☐ Yes	☐ No
Diffficulty Sleeping	☐ Yes	☐ No

Endocrine

Increased Thirst	☐ Yes	☐ No
Increased Hunger	☐ Yes	☐ No
Incread Urination	☐ Yes	☐ No
Increased Sweating	☐ Yes	☐ No
Fingernail Changes	☐ Yes	☐ No

Blood/Lymphnodes

Easy Bruising	☐ Yes	☐ No
Gums Bleed Easily	☐ Yes	☐ No
Prolonged Bleeding	☐ Yes	☐ No
Heavy Aspirin Use	☐ Yes	☐ No

MusculoSkeletal

Stiffness	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Joint Pain/Swelling	☐ Yes	☐ No

Skin

Rash/Sores	☐ Yes	☐ No
Lesions	☐ Yes	☐ No
Hives/Eczema	☐ Yes	☐ No

Neurological

Seizures	☐ Yes	☐ No
Weakness/Paralysis	☐ Yes	☐ No
Numbness	☐ Yes	☐ No
Tremors	☐ Yes	☐ No

Immunologic

Hives	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Runny Nose	☐ Yes	☐ No
Sinus Pressure	☐ Yes	☐ No
Influenza Received	☐ Yes	☐ No
Pneumonia Received	☐ Yes	☐ No

Allergies _____

Past Eye History

_____
_____
_____
_____
_____

Past Eye Surgeries

_____
_____
_____
_____
_____

Current Eye Medications

_____
_____
_____
_____
_____

SEE OTHER SIDE

Past Medical History

Diabetes ☐ Yes ☐ No
Hypertension ☐ Yes ☐ No
Heart Disease ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
If yes, what type?

_____
_____
_____
_____

Past Surgeries ☐ Yes ☐ No

If yes, what surgeries:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Current Medications

Blood Thinners ☐ Yes ☐ No
Diabetic Medication ☐ Yes ☐ No
Other Medications ☐ Yes ☐ No
If yes, please list:

_____
_____
_____
_____
_____
_____

Family History

Diabetes	☐	Blindness	☐	Arthritis	☐
Cancer	☐	Cataracts	☐	Lazy Eye	☐
Heart Disease	☐	Glaucoma	☐	Other/Explanation	☐
Stroke	☐	Macular Degeneration	☐		
TB	☐	Retinal Disease	☐		
Kidney Disease	☐	High Blood Pressure	☐		

Social History

Smoking Status
☐ Never Smoked
☐ Current, every day
☐ Occasional smoker
☐ Former Smoker

Alcohol ☐ Yes ☐ No
If Yes how much? _____

Illegal Drugs used _____
How Much _____
How Long _____
When Quit _____

By signing below you verify that the information listed is correct and up-to-date

Signature: _____

Date: _____