Welcome to Eye Physicians!

Name: _____ **Date:** _____

Email: _____ **Occupation:**_____**Employer:**_____

Your Medical Information: (please circle all that apply)

General: weight loss, chronic fatigue, cancer

Ears/Nose/Throat: chronic cough, ear infection, dry mouth

Cardiovascular: heart disease, high blood pressure, vascular disease

Respiratory: asthma, emphysema, bronchitis

Gastrointestinal: ulcers, colitis, diarrhea, constipation

Kidney/Bladder: dialysis, bladder infection

Musculoskeletal: fibromyalgia, arthritis, ankylosing spondylitis

Skin: acne, eczema, rosacea, psoriasis

Neurological: stroke, seizures

Psychiatric: anxiety, depression, insomnia

Endocrine: diabetes, thyroid disorder, hormone imbalance

Blood: anemia, high cholesterol, leukemia

Immunology: medication allergies, environmental allergies, food allergies

BMI: Your Height_____ Your Weight_____

Are you currently pregnant or nursing? Yes No

Please list all medications (including vitamins and non-prescription supplements) that you are taking.

_____

_____

Your Personal Eye History:

Please list any eye injury, surgery, or disease you currently have or have had in the past:

_____

Do you currently experience…? (Please circle all that apply) Mattery eyes, Sensitivity to light, sudden loss of vision, reading difficulty, blurry distance vision, objects floating in your vision, watery eyes, eyestrain, headaches, double vision, redness of eyes, flashes of light in your vision.

Your Contact Lens History:

Do you currently wear contact lenses? Yes No

If yes, what brand or type? _____

If no, are you interested in trying contact lenses? Yes No

Are you interested in surgical methods, such as Lasik, to correct your vision? Yes No

Your Personal Social History:

Alcohol Use: Never, Occasionally, One drink per day, More than one drink daily

Tobacco Use: Never, Previously but not currently, Less than 1 pack per day, More than 1 pack per day.

Your Family's Medical History: (Do any of your blood relatives have the following? (Please circle all that apply.)

Blindness, Glaucoma, Macular Degeneration, High Blood Pressure, Stroke, Heart Disease, Cancer, Diabetes, Other

Would you like a copy of your clinical summary of today's examination? Yes No