



Name

Name of primary care doctor

Do you wear: Glasses Y / N

Contact lenses Y / N

Do you have any allergies to medications? Y / N If yes, please list:

.....

List any eye medications/drops

.....

List any regular medications

.....

Have you had any previous eye problems / any previous eye surgeries (for instance; cataracts, glaucoma, retinal diseases, macular degeneration, crossed eyes, lazy eye, droopy eyelid, etc)?

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Do you have any medical history / conditions? (for instance; diabetes, high blood pressure, heart problems, arthritis, stroke, thyroid problems, etc)

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Have you had any previous Surgeries?

.....

Do you Smoke? Y / N If yes how much and for how long

Do you drink alcohol? Y / N If yes how much and for how long

Do you drink caffeine? Y / N If yes how much

Do you take any recreational drugs Y / N

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children, living or deceased) for the following:

Blindness Y / N Relationship to you

Glaucoma Y / N Relationship to you

Cataract Y / N Relationship to you

Diabetes Y / N Relationship to you

Heart Disease Y / N Relationship to you

High Blood Pressure Y / N Relationship to you

Other significant disease Y / N Relationship to you

Review of Systems :

Do you have any problems in the following areas?

Constitutional:

Fever, fatigue, or night sweats. Y / N

ENT:

Sinus Congestion Y / N

Headaches Y / N

Respiratory:

Cough Y / N

Asthma Y / N

Chronic Bronchitis Y / N

Cardiovascular:

Chest pain Y / N

Palpitations Y / N

Gastrointestinal:

Vomiting Y / N

Diarrhea or constipation Y / N

Genitourinary:

Burning in urine Y / N

Blood in urine Y / N

Neurological:

Dizziness Y / N

Headaches Y / N

Psychiatric:

Emotional disturbances Y / N

Depression Y / N

Integumentary:

Skin rashes Y / N

Musculoskeletal:

Joint pain/swelling Y / N

Muscle pain Y / N

Hematologic:

Bruising or bleeding. Y / N

Immunology:

Food or environmental allergies Y / N

Patient Signature.....

Date