Patient Demographic & Medical History

Date: ____/____/____

Last Name: _____ Birthdate: ____/____/____

Phone
Home: (____)_____

First Name: _____ MI:____ Male/Female
Circle One

Cell: (____)_____

Street: _____

Work: (____)_____

City: _____ State: _____ Zip: _____

Employer: _____

Email: _____

Occupation: _____

Account Responsible: _____ Phone: _____
Relation: (Self / Spouse / Parent / Other) circle one

School: _____ Sports/Hobbies: _____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS):
Please check any of the following items that apply to you. If you do not have any of these conditions, PLEASE CHECK NONE.

Constitutional:
____ Cancer
____Appetite: Increase/Decrease (circle)
____Weight: Gain/Loss (circle)
____Fatigue
____ Other:
____**NONE**

Genitourinary:
____Frequency of Urination
____Urinary Tract Infection
____STD
____Other:
____**NONE**

Endocrine:
____Diabetes – Insulin
____Diabetes – Non-Insulin
____Hypoglycemic
____Hormonal Dysfunction'
____Thyroid Problem
____Other:
____**NONE**

Social History:
Alcohol: Yes / No
Rare / Occasional / Social / Abuse
Smoker: ____Never
____Former
____Current
Chewing Tobacco: Yes / No
Drug Use: Yes / No

Cardiovascular:
____Hypertension
____Stroke
____Heart Disease
____High Cholesterol
____Peripheral Artery Disease
____Raynaud's
____Congestive Heart Failure
____Other: ____**NONE**

Musculoskeletal:
____Osteoarthritis
____Muscular Dystrophy
____Fibromyalgia
____Other:
____**NONE**

Hematological/Lymph:
____Anemia
____Leukemia
____Lymph Node enlargement
____Lymph Node tenderness
____Other:
____**NONE**

Other Health Disorders:
_____
_____
_____
_____

Ear / Nose / Throat:
____Hearing Loss
____Pharyngitis (sore throat)
____Sinus Infection
____Other:
____**NONE**

Dermatologic:
____Eczema
____Rosacea
____Psoriasis
____Melanoma
____Other:
____**NONE**

Allergies (please List)
Drug / Reaction:
_____
_____
_____
Environmental:
_____
____**NONE**

Respiratory:
____Asthma
____Bronchitis -Acute / Chronic (circle)
____Emphysema
____COPD
____Sarcoidosis
____Sleep Apnea
____Other:
____**NONE**

Neurological:
____Migraines
____Epilepsy
____Multiple Sclerosis
____TIA
____Tumor
____Parkinsons
____Other:
____**NONE**

Immunologic:
____AIDS / HIV
____Rheumatoid Arthritis
____Lupus
____Ankylosing Spondylitis
____Juvenile Rheumatoid Arthritis
____Behcets Syndrome
____Vasculitis
____Other: ____**NONE**

Date & initial that you have reviewed the information on front & back for accuracy.

Gastrointestinal: ____**NONE**
____Crohn's
____Colitis
____Hepatitis
____Irritable Bowel Syndrome
____Diverticulitis
____Other:
____**NONE**

Psychiatric: ____**NONE**
____ADHD
____Depression
____Dementia
____Alzheimer's
____Anxiety
____Other:
____**NONE**

Pregnant: Yes / No

Nursing: Yes / No

Initial **Date**

_____**Reviewed on:**_____

_____**Reviewed on:**_____

_____**Reviewed on:**_____

_____**Reviewed on:**_____

****CONTINUE ON THE OTHER SIDE****

Present / Past Ocular History

PLEASE CHECK IF YOU HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING:

		Date Diagnosed: Eye Surgery / Laser / Injection(s)	Dr / Surgeon: Date of Last treatment:
1	Macular Degeneration (AMD)		
2	Amblyopia (lazy eye)	___/___/___	
3	Blindness	___/___/___	
4	Cataracts Surgery Date: **Right**	___/___/___	
	Surgery Date: **Left**	___/___/___	
5	Diabetic eye disease	___/___/___	
6	Dry Eye (DES)	___/___/___	
7	Eye Injury	___/___/___	
8	Glaucoma	___/___/___	
9	Retinal Disease	___/___/___	
10	Strabismus (eye turn / crossed eye)	___/___/___	
11	Other Eye Disease	___/___/___	

Family History

PLEASE CHECK IF ANYONE IN YOUR FAMILY (PARENTS, GRANDPARENTS, SIBLINGS, CHILDREN, AUNTS OR UNCLES) HAVE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING AND THE RELATION TO YOU.

1 **Amblyopia (lazy eye)** _____
2 **Blindness** _____
3 **Cancer** _____
4 **Cataracts** _____
5 **Diabetes** _____
6 **Eye Turn / Crossed Eye** _____
7 **Glaucoma** _____
8 **Heart Disease** _____
9 **High Blood Pressure** _____
10 **Macular Degeneration** _____
11 **Retinal Disease** _____
12 **Other** _____

Medications

PLEASE LIST **ALL MEDICATIONS & SUPPLEMENTS** THAT YOU ARE TAKING.

EYE MEDS: List all prescription drops, artificial tears and eye vitamins you are taking.

Systemic Medications:	Dosage:	Eye Medications:	Dosage:

****Please return to the front desk when you have completed this sheet. Thank you.****