Name_____ **Date of Birth**_____

Occupation_____ **Gender** Male Female

Race / Ancestry _____

Marital status single / married or domestic partner / widowed / other_____

Allergies + Reactions_____

_____

Tobacco use _____packs per day for _____years **( ) *NONE***

Alcohol consumption - how much / often?_____ **( ) *NONE***

Other substances used _____ **( ) *NONE***

EYE symptoms and history: I have difficulty or problems when / with:

distance vision / near vision / day driving / night driving / reading street signs / reading / glare / using computer / double vision / floaters / flashing light symptoms

eye pain / dry eye / red eye / swollen lids / eye discharge / excessive tearing

glaucoma / cataracts / macular degeneration / diabetic eye disease / lazy eye / eye injury

Other reason for visit: _____

Please list EYE <u>laser treatments</u>, <u>surgery</u>, <u>injuries</u> (which eye, when): ( ) *NONE of these*

_____

_____

_____

Please list other <u>health problems</u>, <u>conditions being treated or monitored</u>, date of onset ( ) *NONE*

_____

_____

_____

Please list any non-eye <u>major surgery</u>, <u>injuries</u>, <u>hospitalizations</u>, with dates ( ) *NONE*

_____

_____

_____

Name_____ **Date of Birth**_____

Please list <u>prescribed</u> and <u>non-prescribed</u> <u>medications</u>, <u>supplements</u>, other <u>substances</u> ( ) *NONE*

( ) See separate page _____

_____

_____

_____

Do you suffer from or have you had: (circle any of the symptoms below which apply to you)

- Recent fever?.....Significant weight loss?..... **NO**
- Hearing loss?.....Sinus problems?.....Difficulty swallowing?..... **NO**
- Chest pain?.....Palpitations?.....Irregular heart beat?.....Foot swelling?..... **NO**
- Shortness of breath?.....Chronic cough?.....Bloody sputum?..... **NO**
- Diarrhea?.....Constipation?.....Bloody stools?.....Abdominal pain?..... **NO**
- Urinary problems?.....Genital discharge? ..... **NO**
- Muscle aches?..... Joint pain? ..... **NO**
- Rashes?.....Changes in skin?.....Breast masses or discharge?..... **NO**
- Memory loss?.....Blackouts?.....Weakness?..... **NO**
- Hallucinations?.....Depression?..... **NO**
- Excessive urination?.....Frequent thirst?.....Fatique?..... **NO**
- Bleeding problems?.....Swollen lymph nodes?.....Frequent infections?..... **NO**
- Other unusual symptoms:_____

Please circle known eye or other medical problems present in <u>family members</u> ( ) *NONE*

Glaucoma	Macular degeneration	Lazy eye	Crossed eyes
Night blindness	Diabetes	Heart disease	Hypertension
Sickle cell disease			

Other:_____