

Name _____
Primary Care Physician _____
When was your last eye exam? _____
By whom? _____

Occupation or hobbies _____
Do you use a computer? Yes No
Do you wear glasses? Yes No
Do you wear contact lenses? Yes No

Past Medical History

1. List all **diseases, illnesses or injuries** you've had: (include eye conditions) _____

2. List all **surgeries** you've had: (include eye surgeries) _____

3. List all **medications** you are taking: (include eye drops, herbs, vitamins and aspirin) _____

Review of Systems: Do you *currently* have problems with any of the following? Circle Yes or No. If yes, please explain.

- Constitutional (fever, unexpected weight loss or gain, fatigue) Yes No _____
- Ear, nose & throat (hearing loss, sore throat, sinus, allergies) Yes No _____
- Cardiovascular (chest pain, irregular heart beat, high BP) Yes No _____
- Respiratory (shortness of breath, coughing, COPD, asthma) Yes No _____
- Gastrointestinal (heartburn, diarrhea, constipation, hernia) Yes No _____
- Urinary (painful or frequent urination, blood in urine, impotence) Yes No _____
- Musculoskeletal (swollen joints, joint pain, arthritis, cramps) Yes No _____
- Skin (skin cancer, pimples, warts, rash, excessive dryness) Yes No _____
- Neurological (numbness, seizures, headache, paralysis) Yes No _____
- Psychiatric (depression, anxiety, bipolar disorder, insomnia) Yes No _____
- Endocrine (diabetes, thyroid, pituitary, adrenal) Yes No _____
- Blood & Lymph (high cholesterol, anemia, bleeding) Yes No _____
- Reproductive (pregnant, nursing, on fertility drugs) Yes No _____
- Do you take or *have you ever taken* **Flomax**? (urinary difficulty) Yes No _____

Family and Social History

1. List all diseases that run in your family: (include eye disease) _____

2. Do you smoke? Yes No Occasionally If yes, how many packs per day? _____
3. Do you drink alcohol? Yes No Occasionally

Technician _____ Date _____ Physician Signature _____