Ocular History:

*Eye Conditions - Have you ever been diagnosed with any of the following conditions?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cataract | Yes | No | Eye infection, inflammation, allergy | Yes | No |
| Macular Degeneration | Yes | No | Floaters and/or flashes of light | Yes | No |
| Glaucoma | Yes | No | Iritis or Uveitis | Yes | No |
| Diabetic Retinopathy | Yes | No | Retina defects or degenerations | Yes | No |
| Dry Eye | Yes | No |  |  |  |
| Please mention any additional conditions: | | | | | |

*Eye/Vision Concerns - Are you having any of the following concerns?*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Redness | Yes | No | Eye pain | Yes | No |
| Burning | Yes | No | Severe Sensitivity to lights | Yes | No |
| Itching | Yes | No | Headache | Yes | No |
| Tearing | Yes | No | Poor night vision | Yes | No |
| Discharge | Yes | No | Bothersome night glare | Yes | No |
| Blurred Vision | Yes | No | Double vision | Yes | No |
| Eyestrain | Yes | No | Total loss of vision | Yes | No |
| Please mention any additional eye/vision concerns: | | | | | |

Medical History:

|  |  |  |  |
| --- | --- | --- | --- |
| List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications): | | | |
| Are you allergic to any medications | Yes | No | If yes, which ones: |

Review of Systems:

Please check the box beside any problem you currently have, or have had, in the following areas

|  |  |  |  |
| --- | --- | --- | --- |
| **Allergic / Immunologic**  Allergy / Hay Fever | All normal | **Hematologic / Lymphatic**  Anemia  Bleeding Problems  Breast Cancer | All normal |
| **Cardiovascular / Cardiac**  Arteriosclerosis  Heart Disease  High Blood Pressure  High Cholesterol | All normal | **Integumentary (Skin)**  Cancer  Rashes  Easy Bruising | All normal |
| **Constitutional**  Fever  Weight Loss / Gain | All normal | **Musculoskeletal**  Rheumatoid Arthritis  Muscle Pain  Joint Pain | All normal |
| **Ears, Nose, Mouth, Throat**  Sinus Congestion  Dry Throat / Mouth | All normal | **Neurological**  Migraines  Dizziness  Seizures  Stroke | All normal |
| **Endocrine**  Diabetes  Thyroid Disease | All normal | **Psychiatric**  Anxiety  Depression  Memory Loss  Hallucinations | All normal |
| **Gastrointestinal**  Diarrhea / Constipation  IBS / IBD / Crohn’s Disease  Ulcers  Reflux | All normal | **Respiratory**  Asthma  Bronchitis  Emphysema  Chronic Cough | All normal |
| **Genitourinary**  Kidney  Ovarian / Uterine Cancer  Prostate Cancer | All normal | **Women who are pregnant or nursing, specify below:**  Pregnant  Nursing |  |

**Patient or Guardian Signature:** **Date:**