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:**