Patient Name: **DOB:**

Current Eye Health:

	No	Yes		No	Yes
Blurry Vision Distance	❒	❒	Floaters or Spots	❒	❒
Blurry Vision Near	❒	❒	Flashes of Light	❒	❒
Eyestrain	❒	❒	Dry Eyes	❒	❒
Poor Night Vision	❒	❒	Burning Eyes	❒	❒
Seeing Halos/Glares	❒	❒	Discharge	❒	❒
Double Vision	❒	❒	Watery Eyes	❒	❒
Crossed eyes	❒	❒	Concerns about Glaucoma/Cataracts	❒	❒

Health History:

Ear/Nose/Throat	No	Yes
Allergies/Hay Fever	❒	❒
Sleep Apnea	❒	❒
Sinus Problems	❒	❒
Chronic Cough	❒	❒
Cardiovascular	N	Y
High Blood Pressure	❒	❒
Cholesterol	❒	❒
Heart Issues	❒	❒
Stroke/TIA	❒	❒
Respiratory	N	Y
Asthma	❒	❒
Chronic Bronchitis	❒	❒
Emphysema	❒	❒
TB	❒	❒
Smoker	❒	❒
Genital/Urinary	N	Y
Kidney Problems	❒	❒
STD	❒	❒
HIV	❒	❒
Gastric/Intestinal	N	Y
Crohn's Colitis	❒	❒
GERD	❒	❒
Jaundice	❒	❒
Muscle/Skeletal	N	Y
Arthritis	❒	❒
Gout	❒	❒
Fibromyalgia	❒	❒
Ankylosing Spondylitis	❒	❒

Endocrine	No	Yes	
Type 1 Diabetes	❒	❒	Yr. Diagnosed: _____
Type 2 Diabetes	❒	❒	Last A1C: _____
Hypothyroid	❒	❒	
Hyperthyroid	❒	❒	
Skin	N	Y	
Acne	❒	❒	
Eczema	❒	❒	
Psoriasis	❒	❒	
Rosacea	❒	❒	
Neurological	N	Y	
Balance Issues	❒	❒	
Dementia	❒	❒	
Tremors	❒	❒	
Vertigo	❒	❒	
Seizure	❒	❒	
Multiple Sclerosis	❒	❒	
Headaches/Migraines	❒	❒	
Psychological	N	Y	
Anxiety	❒	❒	
Depression	❒	❒	
Schizophrenia	❒	❒	
Panic disorder	❒	❒	
PTSD	❒	❒	
Blood/Lymph	N	Y	
Anemia	❒	❒	
Cytomegalovirus	❒	❒	
Immune	N	Y	
Lupus	❒	❒	

Other Conditions Not Listed (please include any cancers):

Please See Other Side

Eye History:	Self		Family:		Who?
	No	Yes	No	Yes	
Glaucoma	❒	❒	❒	❒	
Macular Degeneration	❒	❒	❒	❒	
Retinal Diseases	❒	❒	❒	❒	
Retinal Tear/Detachment	❒	❒	❒	❒	
Cataracts	❒	❒	❒	❒	
Amblyopia (Lazy Eye)	❒	❒	❒	❒	

Are you currently pregnant?
❒ No ❒ Yes
If yes, how many months? _____

Are you currently nursing?
❒ No ❒ Yes
If yes, how many months? _____

Have you had any eye injuries? _____

Do you have any **DRUG ALLERGIES**?
Please List Any Major **Surgeries and Injuries**:
Please List All **MEDICATIONS** and **DOSAGES** (Or Provide Our Front Desk Staff with a List!)
Please List All **VITAMINS AND SUPPLEMENTS**:

Family History:	Mother:	Father:	Sibling:	Other:	Who?
Diabetes	❒	❒	❒	❒	
High Blood Pressure	❒	❒	❒	❒	
Thyroid Issues	❒	❒	❒	❒	
Heart Disease	❒	❒	❒	❒	
Cancer	❒	❒	❒	❒	

Social History:					
Tobacco Use?	❒None	❒Former Smoker	❒Current Smoker:	Someday	Light	Heavy
Alcohol Use?	❒None	❒Occasional	❒Social	❒1-2 Drinks Daily	❒Several Drinks Daily	

Height: _____ ft. _____ in. Weight: _____ lbs

Signature: _____ Date: _____