

DATE: _____ REFERRED BY: _____ FAMILY DOCTOR: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ SEX: F M

SOCIAL SECURITY NUMBER: _____ EMPLOYER: _____

WORK NUMBER: () _____ OCCUPATION (optional)? _____

SPOUSE'S NAME: _____

Please answer the following questions about your medical status and history:

1. Have you ever been treated for any medical conditions(ex: Diabetes,High Blood Pressure,Heart Disease,etc)?

Yes No If YES,please explain: _____

2. Have you ever had any eye disease(ex: Glaucoma,Cataract,Macular degeneration,etc)?

Yes No If YES,please explain: _____

3. Have you had any eye injury/surgeries?

Yes No If YES,please provide date and reason: _____

4. Do you take any medications?

Yes No If YES,please list drug names: _____

5. Do you take any eye medications?

Yes No If YES,please list drug name,date,and time taken last _____

6. Do you have any drug/medication allergies?

Yes No If YES,please list: _____

Review of Systems- Do you currently have any of the following problems:

	Yes	NO	If YES,please explain:
Chronic fever,unexpected weight loss/gain,fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems(ex:hearing loss/sinus problem,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems(ex:chest pain,irregular heart beat,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems(ex:shortness of breathe,coughing,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems(ex:heartburn,abdominal pain,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems(ex:pain,dlscomfort,blood in urine,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems(ex:rash,excessve dryness,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems(ex:muscle aches,joint pain,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems(ex:numbness,weakness,headache,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems(ex:depression,anxiety,etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____

Family and Social History

1. Do any medical or eye disease run in your family(ex:Diabetes,Cataract,Glaucoma,Macular Degeneration)?

Yes No If YES,please list the disease and family relation _____

2. Do you smoke? If YES,how much? _____ Do you drink alcohol? If YES,how much? _____

Physician Signature: _____

Date: _____