Personal & Insurance Information: ***Please Complete*** **Date: _____**

NAME (Mr./ Mrs., Ms, Dr) _____ DOB: _____

Medical History

Do you have **DIABETES?** ☐ YES ☐ NO How many years? _____ Using Medication? ☐ YES ☐ NO

Do you have **HYPERTENSION**? ☐ YES ☐ NO How many years? _____ Using Medication? ☐ YES ☐ NO

Do you have **Cholesterol Problems**? ☐ YES ☐ NO How many years? _____ Using Medication? ☐ YES ☐ NO

Are you **ALLERGIC** to Medications? ☐ YES ☐ NO Which: _____

Medications: (Please list any and all Medication including Over the Counter, Homeopathic, Birth Control or Remedies):

_____

_____

List all Major Injuries, Surgeries, and Hospitalizations you have had:

_____

_____

Review Of Systems (please circle):

Constitutional:	Fever, Weight Loss, Appetite	☐ YES	☐ NO
Integumentary:	Skin conditions/ disorders	☐ YES	☐ NO
Neurological:	Headaches, Migraine, Seizures	☐ YES	☐ NO
Endocrine:	Thyroid/ Endocrine gland problem	☐ YES	☐ NO
Ears, Nose Throat:			
Allergies, Sinus, Cough, Dry Throat/Mouth		☐ YES	☐ NO
Respiratory:	Asthma, Emphysema, Bronchitis	☐ YES	☐ NO
Vascular:	Hypertension, Stroke, Heart Pain	☐ YES	☐ NO
Gastrointestinal:	Diarrhea, Constipation	☐ YES	☐ NO
Genitourinary:	Genitals, Kidneys, Bladder	☐ YES	☐ NO
Bones/ Joints:	Rheumat Arthritis, Muscle Pain	☐ YES	☐ NO
Lymphatic/Hematologic:	Anemia, Bleeding	☐ YES	☐ NO
Allergic Immunologic:	Allergies, Immune	☐ YES	☐ NO
Psychiatric:	Depression/Anxiety	☐ YES	☐ NO

Ocular ROS

			Which EYE?	
Sudden Vision Loss	☐ YES	☐ NO	R	L
Blurred Vision	☐ YES	☐ NO	R	L
Loss of Side Vision	☐ YES	☐ NO	R	L
Double Vision	☐ YES	☐ NO	R	L
Floaters	☐ YES	☐ NO	R	L
Flashes	☐ YES	☐ NO	R	L
Mucus Discharge	☐ YES	☐ NO	R	L
Redness	☐ YES	☐ NO	R	L
Gritty Feeling	☐ YES	☐ NO	R	L
Itching/ Burning	☐ YES	☐ NO	R	L
Tearing/ Watery	☐ YES	☐ NO	R	L
Glare	☐ YES	☐ NO	R	L
Eye Pain/ Discomfort	☐ YES	☐ NO	R	L
Haloes at Night	☐ YES	☐ NO	R	L

_____

Family Ocular & Medical History:

			Relationship to you:
Blindness	☐ YES	☐ NO	_____
Cataracts	☐ YES	☐ NO	_____
Glaucoma	☐ YES	☐ NO	_____
Macular Degeneration	☐ YES	☐ NO	_____
Retinal Disease	☐ YES	☐ NO	_____
Arthritis	☐ YES	☐ NO	_____
Cancer	☐ YES	☐ NO	_____
Diabetes	☐ YES	☐ NO	_____
High Blood Pressure	☐ YES	☐ NO	_____
Heart Disease	☐ YES	☐ NO	_____
Kidney Disease	☐ YES	☐ NO	_____
Thyroid Disease	☐ YES	☐ NO	_____
Any Other?	Explain:		_____

PCP Name:_____

PCP Phone:_____

Last Medical Exam: _____

Are you under any Medical Treatment? ☐ YES ☐ NO

For?_____

Females:

Are you Pregnant/Nursing ☐ YES ☐ NO

Social: (*ALL information is strictly confidential, you may discuss this part with the doctor*) ☐ Check here to discuss with Doctor

Do you Drive? ☐ YES ☐ NO Do you have difficulty driving? ☐ YES ☐ NO Explain_____

Use of tobacco products? ☐ YES ☐ NO Use of alcohol product? ☐ YES ☐ NO Use of Illicit drugs? ☐ YES ☐ NO

Have you been diagnosed / exposed to any Infectious Disease (HIV, TB)? ☐ YES ☐ NO Explain _ _____