PLEASE PRINT

Patient's Name:_____ Date:_____

Family Physician:_____ Physician's Phone:_____

Do you currently have any problems in the following areas? If "yes", provide information.

	Yes	No	Explanation of Problem
Ears, nose, mouth, throat	☐	☐	_____
Respiratory (lungs, breathing)	☐	☐	_____
Cardiovascular (heart/blood vessels)	☐	☐	_____
Gastrointestinal (stomach/intestines)	☐	☐	_____
Genitourinary (genitals/kidney/bladder)	☐	☐	_____
Musculoskeletal (muscle pain, joint pain)	☐	☐	_____
Integumentary (skin and/or breast)	☐	☐	_____
Neurological (nervous system)	☐	☐	_____
Endocrine (thyroid, adrenal, pituitary)	☐	☐	_____
Hematologic (blood)	☐	☐	_____
Lymphatic (lymph nodes)	☐	☐	_____
Allergies (seasonal, foods, hay fever)	☐	☐	_____
Cataracts	☐	☐	_____
Glaucoma	☐	☐	_____
Retinal Disease	☐	☐	_____
Macular Degeneration	☐	☐	_____
Eyelids	☐	☐	_____
Crossed eyes, lazy eye, drooping eyelid, etc.	☐	☐	_____
Do you see an Optometrist for routine eye exams? (If so, whom do you see?)	☐	☐	_____
When was your last eye exam?			_____
Do you wear glasses? (If so, how old are your glasses?)	☐	☐	_____ _____
Do you have allergies to any medications? (If so, please list medications.)	☐	☐	_____ _____
Do you have an allergy to LATEX	☐	☐	
Have you ever been told you have or had MRSA (Methicillin-resistant Staphylococcus aureus)	☐	☐	
Are you currently taking any medication? (If so, please list medications.)	☐	☐	_____ _____ _____

List condition(s) you are being treated for_____ _____

_____ _____

_____ _____

List any surgeries you have had_____ _____

_____ _____

_____ _____

PLEASE PRINT

Family History: If any member of your family (blood relative other than yourself) have or have had any of the following diseases, please fill in the appropriate spaces.

	Yes	No	Relationship to Patient
Blindness	☐	☐	_____
Cataract	☐	☐	_____
Glaucoma	☐	☐	_____
Macular Degeneration	☐	☐	_____
Retinal Disease	☐	☐	_____
Rheumatoid Arthritis	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Attack	☐	☐	_____
Hypertension	☐	☐	_____
Kidney Disease	☐	☐	_____
Thyroid Disease	☐	☐	_____
Stroke	☐	☐	_____
Tuberculosis	☐	☐	_____
Other (explain)	☐	☐	_____

Social History:

Do you drink alcohol?	☐	☐	
If yes, how much per day?			_____
Do you smoke?	☐	☐	
If yes, how much per day?			_____
Have you ever had a blood transfusion?	☐	☐	
Have you ever been in intimate contact with a person who had a sexually transmitted disease?	☐	☐	
Do you drive?	☐	☐	
Do you have any problems driving at night?	☐	☐	
If so, explain.			_____
Current Occupation:			_____

If there is anything more about you that you would like to share with us, please do_____

_____

_____

Physician's signature:_____

Date:_____