NAME : _____ **DATE:** _____

CHIEF COMPLAINT / HISTORY OF PRESENT ILLNESS (REASON FOR VISIT)

_____

_____

_____

DURATION OF COMPLAINT: _____

MEDICAL HISTORY *(CIRCLE ALL THAT APPLY)*

ANXIETY	**CORONARY ARTERY/HEART DISEASE**	**HIGH BLOOD PRESSURE**
ARTHRITIS	**DEPRESSION**	**HYPER/HYPO THYROID**
ASTHMA	**DIABETES**	**SEIZURES**
A-FIB /IRREGULAR HEART BEAT	**END STAGE RENAL DISEASE**	**STROKE**
CANCER (TYPE: _____)	**GERD/ACID REFLUX**	**NONE**
COPD	**HEARING LOSS**	**OTHER** _____

SURGICAL HISTORY *(CIRCLE ALL THAT APPLY)*

APPENDIX	**BYPASS**	**JOINTS**	**OVARIES**	**PROSTATE**	**NONE**
BLADDER	**COLON**	**KIDNEY**	**PACEMAKER**	**SKIN**	**OTHER** _____
BREAST	**GALLBLADDER**	**LIVER**	**PANCREAS**	**UTERUS**	**OTHER** _____

OCULAR / EYE HISTORY *(CIRCLE ALL THAT APPLY)*

CATARACT (RIGHT / LEFT / BOTH EYES)	**NARROW ANGLES** (RIGHT / LEFT / BOTH EYES)
DIABETIC EYE DISEASE (RIGHT / LEFT / BOTH EYES)	**OCULAR HYPERTENSION** (RIGHT / LEFT / BOTH EYES)
DRY EYES (RIGHT / LEFT / BOTH EYES)	**OPHTHALMIC/OCULAR MIGRAINE**
FLASHES OF LIGHT (RIGHT / LEFT / BOTH EYES)	**RETINAL TEAR/DETACHMENT** (RIGHT / LEFT / BOTH EYES)
GLAUCOMA (RIGHT / LEFT / BOTH EYES)	**STRABISMUS** (RIGHT / LEFT / BOTH EYES)
MACULAR DEGENERATION (RIGHT / LEFT / BOTH EYES)	**VITREOUS DETACHMENT** (RIGHT / LEFT / BOTH EYES)
MACULAR WRINKLE/HOLE (RIGHT / LEFT / BOTH EYES)	**VITREOUS FLOATERS** (RIGHT / LEFT / BOTH EYES)
NONE	**OTHER**: _____

NAME: _____ **DATE:** _____

OCULAR / EYE SURGERY *(CIRCLE ALL THAT APPLY)*

CATARACT SURGERY (RIGHT / LEFT / BOTH EYES)
CORNEAL TRANSPLANT (RIGHT / LEFT / BOTH EYES)
GLAUCOMA SURGERY (RIGHT EYE / LEFT EYE)
EYE INJECTIONS (RIGHT / LEFT / BOTH EYES)
EYE MUSCLE SURGERY (RIGHT / LEFT / BOTH EYES)
REFRACTIVE SURGERY (RIGHT / LEFT / BOTH EYES)
RETINAL TEAR/DETACHMENT/LASER (RIGHT/LEFT/BOTH)
YAG LASER AFTER CATARACT SURGERY(RIGHT/LEFT/BOTH)

MEDICATIONS *(LIST ALL CURRENT EYE, ORAL AND OVER THE COUNTER MEDICATIONS AND VITAMINS)*

_____

_____

_____

ALLERGIES *(LIST ALL ALLERGIES TO MEDICATION OR FOOD)*

_____

_____

SOCIAL HISTORY *(CIRCLE ALL THAT APPLY)*

SMOKING STATUS: NEVER / CURRENT / PREVIOUS (**TOTAL YEARS** _____ **PACKS PER DAY** _____)

DO YOU DRINK ALCOHOL? YES / NO **HOW MANY DRINKS PER DAY?** _____

DRIVING STATUS: CURRENTLY DRIVING IN THE DAYTIME / DRIVING IN THE NIGHT / NO LONGER DRIVING

DO YOU LIVE ALONE? YES / NO

WHO DO YOU LIVE WITH: _____

OCCUPATION: _____CURRENTLY WORKING / RETIRED

HOBBIES: _____

FAMILY HISTORY *(CIRCLE ALL THAT APPLY and STATE FAMILY MEMBER HISTORY APPLIES TO)*

BLINDNESS _____
CANCER _____
DIABETES _____
GLAUCOMA _____
HEART DISEASE _____
HYPERTENSION _____
MACULAR DEGENERATION _____
RETINAL DETACHMENT _____
STROKE _____