TODAY'S DATE:_____

NAME:_____ DATE OF BIRTH_____

REFERRING PHYSICIAN:_____

WHY DID YOU SCHEDULE AN EYE EXAM?_____

_____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?

	No	Yes		No	Yes		No	Yes
Eye surgery	☐	☐	Stroke	☐	☐	Arthritis	☐	☐
Eye Laser	☐	☐	Irregular heart beat	☐	☐	HIV/AIDS	☐	☐
Eye Trauma	☐	☐	Anemia	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Bleeding problems	☐	☐	Migraines	☐	☐
Macular Degeneration	☐	☐	Lung problems/COPD	☐	☐	Seizures	☐	☐
Glaucoma	☐	☐	Asthma	☐	☐	Cancer	☐	☐
High blood pressure	☐	☐	Kidney disease	☐	☐	Thyroid disease	☐	☐
Heart disease	☐	☐	Liver disease	☐	☐			

	No	Yes	
DO YOU SMOKE?	☐	☐	How many packs per day? _____ For how many years? _____
DO YOU DRINK ALCOHOL?	☐	☐	How many drinks per day?
RECREATIONAL DRUGS?	☐	☐	What names?_____

OCCUPATION:_____

DOES ANYONE IN YOUR FAMILY HAVE ANY OF THE FOLLOWING CONDITIONS?

	No	Yes: Mom	Dad	Sister	Brother	Son	Daughter	Grandfather	Grandmother
Blindness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Macular degeneration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐	☐	☐	☐
Retinal detachment	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐

ANY ALLERGIES TO MEDICATIONS (e.g., penicillin, sulfa, iodine)?_____

NAMES OF MEDICATIONS (or please attach list):

☐ Currently not on any medications

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Examiner _____

DO YOU HAVE ANY OF THE FOLLOWING?	No	Yes
Fevers, unintentional weight loss	☐	☐
Heart Problems (chest pain, irregular beat)	☐	☐
Lung problems (shortness of breath, cough)	☐	☐
Gastrointestinal problems (pain, diarrhea)	☐	☐
Urinary problems (pain, blood, incontinence)	☐	☐
Skin problems (rashes, rosacea, infections)	☐	☐
Musculoskelatal problems (joint swelling, pain)	☐	☐
Neurologic problems (numbness, weakness)	☐	☐
Psychiatric problems (depression, anxiety)	☐	☐
Ear, nose, or throat problems?	☐	☐

Please explain:_____

_____

Patient/guardian signature_____