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|--|---------------------------------------|----------|----------|--|-------------|----------|
| Date _____ Name _____ Please list medications you are currently taking: None _____ _____ _____ _____ List any eye drops you are using: _____ _____ | Do you have: | | | Do you : | | |
| | General Allergies? | Y | N | Have Glaucoma? | Y | N |
| | Sinus Problems ? | Y | N | Have Cataracts? | Y | N |
| | Headaches? | Y | N | High Blood Pressure? | Y | N |
| | Eye pain? | Y | N | Diabetes? | Y | N |
| | Dry Eyes ? | Y | N | Do you take insulin? | Y | N |
| | Eye redness? | Y | N | Have HIV? | Y | N |
| | Eyes burn? | Y | N | Work with a computer? | Y | N |
| | Eyes itch? | Y | N | Play sports in which safety Is a factor? | Y | N |
| | Eyes water? | Y | N | Drive an excessive amount ? | Y | N |
| Drug Allergies: None Known _____ _____ _____ | Eye mucous? | Y | N | Have a problem with sunlight? | Y | N |
| | Has anyone in your family had: | | | | | |
| | Glaucoma | Y | N | Who? | _____ | |
| | Diabetes | Y | N | Who? | _____ | |
| | Cataracts | Y | N | Who? | _____ | |
| | High Blood Pressure | Y | N | Who? | _____ | |
| Any other eye disease | Y | N | Who? | _____ | What? _____ | |

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| <p>Allergic/ Immunologic</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> drug/allergy <input type="checkbox"/> environmental allergy <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> lupus <p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> stroke <input type="checkbox"/> vascular disease <input type="checkbox"/> Congestive Heart Failure <p>Constitutional</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> developmental disability <input type="checkbox"/> weight loss <input type="checkbox"/> fever <input type="checkbox"/> fatigue <input type="checkbox"/> trauma <input type="checkbox"/> Involved in motor vehicle accident <p>Ear, nose, mouth & throat</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> Upper resp tract inf <input type="checkbox"/> Ear infection <input type="checkbox"/> sore throat <input type="checkbox"/> runny nose <input type="checkbox"/> trouble swallowing | <p>Endocrine</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> non-insulin diabetes <input type="checkbox"/> insulin diabetes <input type="checkbox"/> thyroid dysfunction <input type="checkbox"/> hormonal dysfunction <p>Gastrointestinal</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> Crohn's <input type="checkbox"/> colitis <input type="checkbox"/> ulcer <input type="checkbox"/> digestive <input type="checkbox"/> hiatal hernia <input type="checkbox"/> gallbladder <input type="checkbox"/> Hepatitis <input type="checkbox"/> pancreatitis <p>Hematological/ Lymphatic</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> anemia <input type="checkbox"/> Ig volume blood loss <input type="checkbox"/> leukemia <p>Integumentary</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> eczema <input type="checkbox"/> rosacea <input type="checkbox"/> psoriasis <p>Muskuloskeletal</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> fibromyalgia <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> osteoarthritis | <p>Neurological</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> epilepsy <input type="checkbox"/> head injury <input type="checkbox"/> stroke _____ <input type="checkbox"/> Alzheimer's <input type="checkbox"/> Fainting/ Blackouts <input type="checkbox"/> Dizziness <p>Psychiatric</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> depression <input type="checkbox"/> panic disorder <input type="checkbox"/> schizophrenia <input type="checkbox"/> Bipolar disorder <p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> cigarette smoker <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis <input type="checkbox"/> emphysema <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Lung cancer <p>Genitourinary</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> STD – viral, herpetic, chlamydia <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Prostate Cancer <input type="checkbox"/> Cervical/Uterine/ Ovarian Cancer <input type="checkbox"/> Pregnant | <p>Patient Ocular History</p> <ul style="list-style-type: none"> <input type="checkbox"/> NONE <input type="checkbox"/> Glasses <input type="checkbox"/> Contact Lenses <input type="checkbox"/> Glaucoma RT LT <input type="checkbox"/> Retinal Detachment RT LT <input type="checkbox"/> Macular Degeneration RT LT <input type="checkbox"/> Retinitis Pigmentosa RT LT <input type="checkbox"/> Iritis / Uvetitis RT LT <input type="checkbox"/> Cataracts RT LT <input type="checkbox"/> Crossed eyes/ Strabismus <input type="checkbox"/> Ocular migraines <input type="checkbox"/> field loss <input type="checkbox"/> photophobia <input type="checkbox"/> redness <input type="checkbox"/> itching <input type="checkbox"/> burning <input type="checkbox"/> recurrent styes <input type="checkbox"/> Eye Surgery RT LT <input type="checkbox"/> Flashes <input type="checkbox"/> Floaters <input type="checkbox"/> Recurring styes <p>Family Ocular History</p> <ul style="list-style-type: none"> <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinal detachment <input type="checkbox"/> Macular degeneration <input type="checkbox"/> Retinitis Pigmentosa <input type="checkbox"/> Blindness for any reason |
|---|--|--|---|

No changes as of _____ **Pt/Guardian signature:** _____

No changes as of _____ **Pt/Guardian signature:** _____