

Date _____ Name _____ Medications _____ _____ _____ _____ _____ _____ _____ Drug Allergies _____ _____ _____ _____ _____	Do you have: General Allergies? Y N High Blood Pressure? Y N Diabetes ? Y N Do you take insulin? Y N Headaches? Y N Sinus Problems ? Y N Eye redness? Y N Glaucoma? Y N Cataracts? Y N Dry Eyes ? Y N Eye pain? Y N Has anyone in your family had: Glaucoma Y N Diabetes Y N Cataracts Y N High Blood Pressure Y N Any other eye disease Y N	Do your eyes? Itch Y N Water Y N Burn Y N Do you: Work with a computer? Y N Play sports in which safety Is a factor? Y N Drive an excessive amount Y N Have a problem with sunlight Y N Use any eye drops? Y N Please list _____ _____ Who? _____ Who? _____ Who? _____ Who? _____ Who? _____ What?
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Allergic/ Immunologic <input type="checkbox"/> NONE <input type="checkbox"/> drug/allergy <input type="checkbox"/> environmental allergy HIV / AIDS <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> lupus Cardiovascular <input type="checkbox"/> NONE <input type="checkbox"/> heart disease <input type="checkbox"/> High blood pressure <input type="checkbox"/> stroke <input type="checkbox"/> vascular disease Congestive Heart Failure Constitutional <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 Ear, nose, mouth & throat <input type="checkbox"/> NONE <input type="checkbox"/> Upper resp tract inf Ear infection sore throat runny nose trouble swallowing	Endocrine <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 Gastrointestinal <input type="checkbox"/> NONE <input type="checkbox"/> Crohn's <input type="checkbox"/> colitis <input type="checkbox"/> ulcer <input type="checkbox"/> digestive hiatal hernia gallbladder Hepatitis pancreatitis Hematological/ Lymphatic <input type="checkbox"/> NONE <input type="checkbox"/> anemia <input type="checkbox"/> lg volume blood loss <input type="checkbox"/> leukemia Integumentary <input type="checkbox"/> NONE <input type="checkbox"/> eczema <input type="checkbox"/> rosacea <input type="checkbox"/> psoriasis Muskuloskeletal <input type="checkbox"/> NONE <input type="checkbox"/> fibromyalgia <input type="checkbox"/> muscular dystrophy <input type="checkbox"/> osteoarthritis	Neurological <input type="checkbox"/> NONE <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> epilepsy <input type="checkbox"/> head injury stroke _____ Alzheimer's Fainting/ Blackouts Dizziness Psychiatric <input type="checkbox"/> NONE <input type="checkbox"/> depression <input type="checkbox"/> panic disorder <input type="checkbox"/> schizophrenia <input type="checkbox"/> Bipolar disorder Respiratory <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 Lung cancer Genitourinary <input type="checkbox"/> NONE <input type="checkbox"/> STD – viral, herpetic, chlamydia Kidney Disease Prostate Cancer Cervical/Uterine/ Ovarian Cancer Pregnant	Patient Ocular History <input type="checkbox"/> NONE Glasses Contact Lenses Glaucoma RT LT Retinal Detachment Macular Degeneration Retinal Pigmentosa Iritis / Uvetitis RT LT Cataracts RT LT Crossed eyes/ Strabismus Ocular migraines field loss photophobia redness itching burning recurrent styes Eye Surgery RT LT Flashes Floaters Recurring styes Family Ocular History Glaucoma Retinal detachment Macular degeneration Retinitis Pigmentosa Blindness for any reason
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