Name: _____ Date: _____ / _____ / _____

Mailing Address: _____ Phone: _____

_____ Height:_____ Weight:_____

DOB: ___ / ___ / ___ SS# ____ / ____ / ____ Occupation:_____ PCP:_____

Email:_____

Review Of Systems:

Neuro:
Headache Y / N
Migraine Y / N

Eyes:
Blur Y / N
Loss of Vision Y / N
Pain / Sore Y / N
Redness Y / N
Dryness Y / N
Double Vision Y / N
Flashes Y / N
Floaters Y / N

Hematologic:
Anemia Y / N
Bleeding Pro Y / N
Sickle Cell Y / N

Last Fasting Blood Sugar:_____
A1C:_____

Ears Nose Throat:
Allergy Y / N
Cough Y / N

Respiratory:
Asthma Y / N
Bronchitis Y / N
COPD Y / N
Emphysema Y / N

Auto-Immune:
Lupus Y / N
Sjogrens Y / N
AIDS / HIV Y / N
Lymes Y / N

Endocrine:
Diabetes Y / N
1 or 2
Thyroid Y / N
Hyper or Hypo

CardioVascular:
Heart Dis. Y / N
Hypertension Y / N
Artery Dis. Y / N

Genitourinary/ Gastro:
Crohns Dis. Y / N
IBS Y / N
Kidney Dis. Y / N
Bladder Dis. Y / N
other: _____

Psychiatric:
Depression Y / N
Bi-Polar Y / N
Dementia Y / N
Alzheimer's Y / N
Brain Injury Y / N
Other:_____

Please list any treatments:_____
_____
_____
_____
_____
_____
_____
_____

Cancer:
Type: _____
_____
_____

Do you have any Allergies to Medications: if yes list and explain reaction
_____
_____
_____
_____

List any Medications you currently take:
_____
_____
_____
_____

_____Initial Date:_____

Continued on Back —>

Social History

(Circle one)

***Tobacco**: **Smoke** ___pk/day **Smokeless** ___can/week **None**
If yes how long: _____
***Alcohol** ___drinks/month Type:_____ **None**
If yes how long: _____
***Recreational Drug Use** Type:_____ **None**
If yes how long: _____

Family Medical History:	Mother	Father	Brother	Sister	Son	Daughter
Cancer						
Diabetes I						
Diabetes II						
High Blood Pressure						
Hyper-Thyroid						
Hypo-Thyroid						

Family Ocular History:						
Cataracts						
Macular Deg.						
Glaucoma						
Diabetic Retinopathy						
Lazy Eye						
Blindness						

Pregnancy: Y / N _____months Nursing: Y/N Glasses: Y / N Contacts: Y / N Soft Hard
Surgeries / Hospitalizations: _____
_____
_____

How Do You Use Your Eyes???

1. How many hours per day do you use computer / Phone / iPad or Tablet: _____hrs/day
2. Do you ever find yourself participating in activity that needs eye protection? Y / N
   which activity?:_____
3. Do you play sports or participate in outdoor activities? Which ones: _____
   _____
4. List any hobbies you have? _____
   _____
5. Do you drive for a living or spend a great deal of your day driving? Y / N
6. Do you find you have sensitivity to glare and light? Y / N

Dr. Signature:_____ Date: _____