Last Name: ______________________ **First Name:** ______________________ **MI:** ______ **DOB:** ____/____/____

General Physician / Pediatrician: ______________________ **Occupation or School grade:** ______________________

To insure that your records are accurate and for insurance compliance, please complete and update *all* of the following information

Past (Personal), Family and Social History:

Medication Allergies: ☐Y ☐N
1. ____________ 3. ____________
2. ____________ 4. ____________

Non-Medication Allergies: ☐Y ☐N
1. ____________ 3. ____________
2. ____________ 4. ____________

Eye Medications - Prescription & OTC: ☐Y ☐N
1. ____________ ☐R ☐L Frequency: ________
2. ____________ ☐R ☐L Frequency: ________
3. ____________ ☐R ☐L Frequency: ________
4. ____________ ☐R ☐L Frequency: ________

General Medications - Prescription & OTC: ☐Y ☐N
1. ____________ 5. ____________
2. ____________ 6. ____________
3. ____________ 7. ____________
4. ____________ 8. ____________

Previous Eye Surgery &/or Procedure(s): ☐Y ☐N
1. ____________ Date: ___/___/___
2. ____________ Date: ___/___/___
3. ____________ Date: ___/___/___
4. ____________ Date: ___/___/___
5. ____________ Date: ___/___/___

Previous General Surgery &/or Procedure(s): ☐Y ☐N
1. ____________ Date: ___/___/___
2. ____________ Date: ___/___/___
3. ____________ Date: ___/___/___
4. ____________ Date: ___/___/___
5. ____________ Date: ___/___/___

Previous Significant Injuries: ☐Y ☐N
1. ____________ 3. ____________
2. ____________ 4. ____________

Previous Significant Illnesses: ☐Y ☐N
1. ____________ 3. ____________
2. ____________ 4. ____________

Family Eye History: (Note: M = mother, F = father, etc.)

Cataracts:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Glaucoma:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Macular Degen.:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Retinal Detach.:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________

Other: ______________________

Family Medical History: (Note: M = mother, F = father, etc.)

Cancer:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Diabetes:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Heart Disease:	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________
Inherited Disease	☐No	☐Yes:	☐M	☐F	☐GM	☐GF	☐________

Other: ______________________

Social History: Do you Smoke? ☐Y ☐Former ☐Never Drink alcohol? ☐Y ☐N ☐Occasionally

Review of Systems: **Height:**____ ft _____ inches **Weight:**_______ lbs

Allergic/Immunologic
- Hay fever: ☐Y ☐N
- Lupus (SLE): ☐Y ☐N

Cardiovascular (Heart/Vessels)
- Elevated cholesterol: ☐Y ☐N
- Heart disease: ☐Y ☐N
- High blood pressure: ☐Y ☐N

Constitutional
- Fever: ☐Y ☐N

Ears/Nose/Mouth/Throat
- Dry mouth: ☐Y ☐N
- Fever blisters (lip): ☐Y ☐N

Endocrine
- Diabetes (insulin): ☐Y ☐N
- Diabetes (non-insulin): ☐Y ☐N
- Hypo-Thyroid condition: ☐Y ☐N
- Hyper-Thyroid condition: ☐Y ☐N

Eyes
- Allergies (eye): ☐Y ☐N
- Amblyopia ("lazy eye"): ☐Y ☐N
- Blepharitis: ☐Y ☐N
- Cataract: ☐Y ☐N
- Choroidal nevus: ☐Y ☐N
- Color vision deficiency: ☐Y ☐N
- Diabetic retinopathy: ☐Y ☐N
- Dry eyes: ☐Y ☐N
- Glaucoma: ☐Y ☐N
- Glaucoma suspect: ☐Y ☐N
- Iritis / Uveitis: ☐Y ☐N
- Keratoconus: ☐Y ☐N
- Macular degeneration: ☐Y ☐N
- Optic Neuritis.: ☐Y ☐N
- Retinal tear / detach.: ☐Y ☐N
- Strabismus (eye turn): ☐Y ☐N

Gastrointestinal
- Diarrhea: ☐Y ☐N
- Loss of appetite: ☐Y ☐N
- Nausea: ☐Y ☐N

Genitourinary
- Bladder disorder: ☐Y ☐N
- Kidney disorder: ☐Y ☐N
- Sexually trans. disease: ☐Y ☐N

Hematologic/Lymphatic
- Anemia: ☐Y ☐N
- Leukemia: ☐Y ☐N
- Lymphoma: ☐Y ☐N

Integumentary (Skin)
- Easy bruising: ☐Y ☐N
- Skin cancer: ☐Y ☐N
- Melanoma: ☐Y ☐N
- Problematic acne: ☐Y ☐N

Musculoskeletal
- Arthritis: ☐Y ☐N
- Fibromyalgia: ☐Y ☐N
- Osteoporosis: ☐Y ☐N

Neurological
- Migraines: ☐Y ☐N
- Multiple Sclerosis: ☐Y ☐N
- Seizure disorder: ☐Y ☐N
- Stroke: ☐Y ☐N

Psychiatric ☐Y ☐N
- Anxiety disorder: ☐Y ☐N
- Depression: ☐Y ☐N

Respiratory (Lungs / Breathing)
- Asthma: ☐Y ☐N
- Chronic bronchitis ☐Y ☐N
- Emphysema: ☐Y ☐N
- Shortness of breath: ☐Y ☐N

Additional conditions/information: ______________ ______________ ______________

Patient Signature & Date - (Note: If the patient is a minor or under the care of a legal guardian, the legal guardian must sign and date):

______________________ ____/____/____
Signature Date