



DATE _____

REFERRED BY _____		PRIMARY CARE PHYSICIAN _____	PREVIOUS EYE DOCTOR _____	
PATIENT NAME _____		BIRTHDATE _____	SEX <input type="checkbox"/> M <input type="checkbox"/> F	AGE _____
ADDRESS _____			HOME PHONE _____	
EMPLOYER _____		OCCUPATION _____	WORK PHONE _____	

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY

- Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc.) Yes → Please explain No
- Have you ever had any eye disease? (e.g. glaucoma, cataract, "lazy" eye, retinal detachment) Yes → Please explain No
- Have you ever had any surgery? Yes → Please explain No
- Have you ever been hospitalized? Yes → Please explain No
- Do you take medications? (including eye medications) Yes → Please explain No
- Do you have any food or drug allergies? Yes → Please explain No

REVIEW OF SYSTEMS	DO YOU CURRENTLY HAVE ANY OF THE FOLLOWING PROBLEMS?		IF YES, PLEASE EXPLAIN
	YES	NO	
Chronic fever, unexpected weight loss/gain, fatigue			
Ear / nose / throat problems (e.g. hearing loss, sinus, sore throat)			
Heart problems (e.g. chest pain, irregular heart beat)			
Respiratory problems (shortness of breath, wheezing, coughing)			
Gastrointestinal problems (heartburn, abdominal pain, diarrhea, vomiting)			
Urinary problems (pain or discomfort, blood in urine)			
Skin problems (rashes, excessive dryness)			
Musculoskeletal problems (muscle aches, joint pain)			
Neurologic problems (numbness, weakness, headaches)			
Psychiatric problems (depression, anxiety)			

FAMILY & SOCIAL HISTORY

Do any medical or eye diseases run in your family? (diabetes, high blood pressure, cancer, glaucoma, macular degeneration) No Yes → Please explain

Do you smoke? Yes → How much? No

Do you drink alcohol? Yes → How much? No

If employed, how many hours per week do you work? _____

COMMENTS

MD SIGNATURE _____ DATE _____