



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_  
 Primary Care Dr \_\_\_\_\_ Last eye exam \_\_\_\_\_ Performed by Dr \_\_\_\_\_

<b>EYE HISTORY</b>	<b>YOURSELF</b>	<b>FAMILY</b>	<b>EYE SURGERY HISTORY</b>	<b>DATE</b>
Glaucoma	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Cataract	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Diabetic retinopathy	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Macular degeneration	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Retinal Detachment	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____	_____
Trauma to the eye	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wear glasses?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Poor vision since birth	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Always <input type="checkbox"/> Occasionally	<input type="checkbox"/> Reading <input type="checkbox"/> Driving
Crossed eyes	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Do you wear contacts?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dry eyes	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	Brand _____	Hrs/Day _____

<b>PAST MEDICAL HISTORY</b>	<b>PAST SURGICAL HISTORY</b>	<b>DATE</b>
<input type="checkbox"/> Diabetes _____ yrs	<input type="checkbox"/> Asthma	_____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Arthritis	_____
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> COPD	_____
<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Seizures	_____
<input type="checkbox"/> Hospice	<input type="checkbox"/> Dialysis	_____

<b>SOCIAL HISTORY</b>	<b>ANESTHESIA HISTORY</b>
Do you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO	Have you had any complications from anesthesia? <input type="checkbox"/> YES <input type="checkbox"/> NO/? <input type="checkbox"/>
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO	FORMER <input type="checkbox"/> _____ yrs
Recent weight change? <input type="checkbox"/> YES <input type="checkbox"/> NO	frequency _____
Regular exercise? <input type="checkbox"/> YES <input type="checkbox"/> NO	gain/loss _____ lbs
	_____ times/week
	Ever diagnosed with malignant hyperthermia? <input type="checkbox"/> YES <input type="checkbox"/> NO/? <input type="checkbox"/>
	Family members with malignant hyperthermia? <input type="checkbox"/> YES <input type="checkbox"/> NO/? <input type="checkbox"/>

<b>REVIEW OF SYSTEMS</b>			
<b>EAR, NOSE, AND THROAT</b>	<b>RESPIRATORY</b>	<b>PSYCHIATRIC</b>	<b>BLOOD/LYMPHNODES</b>
HARD OF HEARING <input type="checkbox"/>	COUGH <input type="checkbox"/>	ANXIETY/DEPRESSION <input type="checkbox"/>	EASY BRUISING <input type="checkbox"/>
RINGING IN EARS <input type="checkbox"/>	CONGESTION <input type="checkbox"/>	MOOD SWINGS <input type="checkbox"/>	GUMS BLEEDING <input type="checkbox"/>
VERTIGO <input type="checkbox"/>	WHEEZING <input type="checkbox"/>	DIFFICULTY SLEEPING <input type="checkbox"/>	PROLONGED BLEEDING <input type="checkbox"/>
<b>CARDIOVASCULAR</b>	ASTHMA <input type="checkbox"/>	<b>ENDOCRINE</b>	HEAVY ASPIRIN USE <input type="checkbox"/>
CHEST PAIN <input type="checkbox"/>	<b>GASTROINTESTINAL</b>	INCREASED THIRST <input type="checkbox"/>	<b>MUSCULOSKELETAL</b>
DIZZINESS <input type="checkbox"/>	HEARTBURN <input type="checkbox"/>	INCREASED HUNGER <input type="checkbox"/>	STIFFNESS <input type="checkbox"/>
FAINING SPELLS <input type="checkbox"/>	NAUSEA/VOMITING <input type="checkbox"/>	INCREASED URINATION <input type="checkbox"/>	ARTHRITIS <input type="checkbox"/>
SHORTNESS OF BREATH <input type="checkbox"/>	JAUNDICE/HEPATITIS <input type="checkbox"/>	INCREASED SWEATING <input type="checkbox"/>	JOINT PAIN/SWELLING <input type="checkbox"/>
IRREGULAR HEART BEAT <input type="checkbox"/>	<b>URINARY</b>	FINGERNAIL CHANGES <input type="checkbox"/>	<b>SKIN</b>
DIFFICULTY LYING FLAT <input type="checkbox"/>	PAIN/DIFFICULTY <input type="checkbox"/>	<b>NEUROLOGICAL</b>	RASH/SORES <input type="checkbox"/>
<b>CONSTITUTIONAL</b>	BLOOD IN URINE <input type="checkbox"/>	SEIZURES <input type="checkbox"/>	ECZEMA <input type="checkbox"/>
FATIGUE/WEAKNESS <input type="checkbox"/>	KIDNEY STONES <input type="checkbox"/>	WEAKNESS/PARALYSIS <input type="checkbox"/>	LESIONS <input type="checkbox"/>
FEVER <input type="checkbox"/>	HISTORY OF STD'S <input type="checkbox"/>	NUMBNESS <input type="checkbox"/>	HIVES <input type="checkbox"/>
WEIGHT GAIN/LOSS <input type="checkbox"/>		TREMORS <input type="checkbox"/>	

**Patient signature (please complete the back of this form before signing)**

\_\_\_\_\_  
 Patient or guardian

\_\_\_\_\_  
 Date