

Name: _____ DOB: _____

Allergies: _____

Medical Issues: _____ Medications: _____

Surgeries: _____

Past Eye Surgeries: _____

Eye Conditions:

- | | |
|---------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> Eyes cross in toward nose | <input type="checkbox"/> Eyes drift outward |
| <input type="checkbox"/> chronic tearing in infancy | <input type="checkbox"/> Poor vision one eye (amblyopia) ___ Right ___ Left |
| <input type="checkbox"/> Myopia (near sightedness) | <input type="checkbox"/> Hyperopia (far sighted) |
| <input type="checkbox"/> Astigmatism (distorted vision) | <input type="checkbox"/> High eye pressure/glaucoma |
| <input type="checkbox"/> Other: _____ | |

Family History:

- | | |
|--------------------------------------------------------|-----------------------------------------------------------------------------|
| <input type="checkbox"/> strabismus (eyes cross/drift) | <input type="checkbox"/> poor vision one eye from childhood (amblyopia) |
| <input type="checkbox"/> Cataract as child/young adult | <input type="checkbox"/> Cataract as adult/elderly |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Myopia (near sighted) |
| <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Nystagmus (constant back & forth movement of eyes) |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Other _____ |

Review of Systems: Please check any that apply to the patient and explain if necessary

<input type="checkbox"/>	Constitutional	<input type="checkbox"/>	Respiratory	<input type="checkbox"/>	Allergic/immunology
<input type="checkbox"/>	Recurrent fever	<input type="checkbox"/>	cough	<input type="checkbox"/>	Hives/eczema
<input type="checkbox"/>	Fatigue/weakness	<input type="checkbox"/>	wheezing	<input type="checkbox"/>	seasonal allergies
<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	Gastrointestinal	<input type="checkbox"/>	Itching eyes
<input type="checkbox"/>	Ear, Nose, Throat	<input type="checkbox"/>	nausea	<input type="checkbox"/>	Musculoskeletal
<input type="checkbox"/>	Difficulty hearing	<input type="checkbox"/>	constipation	<input type="checkbox"/>	Joint pain or swelling
<input type="checkbox"/>	Ringling in hears	<input type="checkbox"/>	diarrhea	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Skin
<input type="checkbox"/>	Cardiovascular	<input type="checkbox"/>	Genitourinary	<input type="checkbox"/>	Rash
<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	Kidney issues	<input type="checkbox"/>	lesions
<input type="checkbox"/>	Dizziness/ fainting spells	<input type="checkbox"/>	Urinary tract issues	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	Hematology/lymphatic	<input type="checkbox"/>	headaches
<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	Easy bruising	<input type="checkbox"/>	Low muscle tone
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Clotting disorder	<input type="checkbox"/>	Delay in development

Comments: _____

OFFICE USE: history reviewed (initial/date) _____
