Patient History

Past Medical History

Please circle all that apply:

Anxiety	Hepatitis	Hearing Loss	COPD
Arthritis	Hypertension	GERD	Depression
Artificial Joints	HIV/AIDS	Valve Replacement	Seizures
Asthma	Hypercholesterolemia	Stroke	Diabetes
Atrial fibrillation	Hyperthyroidism	BPH	Pacemaker
Bone Marrow Transplantation	End Stage Renal Disease	Other:_____	

Cancer

Please circle all that apply:

Breast Cancer	Leukemia	Basal Cell	Squamous Cell
Colon Cancer	Prostate Cancer	Uterine Cancer	Lung Cancer
Ovarian Cancer	Lymphoma	Other: _____	

Past Surgical History

Please circle all that apply:

Appendix Removed	Breast Reduction	Endometriosis
Bladder Removed	Fibroids Hysterectomy	Hysterectomy
Mastectomy (Right, Left, Bilateral)	Colectomy: Colon Cancer Resection	Ovaries Removed
Lumpectomy (Right, Left, Bilateral)	Colectomy: Diverticulitis	Spleen Removed
Breast Biopsy (Right, Left, Bilateral)	Colectomy: IBD	Skin Biopsy
Gallbladder Removed	Coronary Artery Bypass	Heart Transplant
Mechanical Valve Replacement	Biological Valve Replacement	Breast Implants
Knee Replacement (Right, Left, Bilateral)	Hip Replacement (Right, Left, Bilateral)	Kidney Stone Removal
Kidney Biopsy or Transplant	Kidney Removed (Right, Left)	Prostate Removed
Prostate Biopsy TURP	Testicles Removed (Right, Left, Bilateral)	Other: _____

Family History

Please circle all that apply & list relationship to diagnosed:

Blindness	Cancer	Cataracts	CVA	Diabetes
Glaucoma	Heart Disease	Migraine	Strabismus	
Retinal Detachment	Macular Degeneration	None	Other: _____	

Ocular History

Please circle all that apply:

Allergic Conjunctivitis	Diabetic Retinopathy (Right, Left)	Blepharitis
Dry Eyes	Cataract (Right, Left, Both)	Glaucoma (Right, Left)
Corneal Dystrophy (Right, Left, Both)	Macular Degeneration (Right, Left)	Ophthalmic Migraine
Macular ERM (Right, Left)	Narrow Angles (Right, Left)	PVD (Right, Left)
Ocular Hypertension (Right, Left)	Pseudo exfoliation (Right, Left)	Retinal Tear (Right, Left)
Strabismus (Right, Left)	Floaters (Right, Left)	None
Other: _____		

Ocular Surgical History

Please circle all that apply:

Blepharoplasty (Right, Left)	Corneal Transplant (Right, Left)	Laser PI (Right, Left)
Cataract Surgery (Right, Left)	DSAEK (Right, Left)	PRK (Right, Left)
Eye Muscle Surgery	Intravitreal Injections (Right, Left)	Tube Shunt (Right, Left)
Lasik (Right, Left)	SLT/ALT Glaucoma Laser (Right, Left)	Ptosis Repair (Right, Left)
Punctal Plugs (Right, Left)	Retinal Laser (Right, Left)	None
Trabeculectomy (Right, Left)	YAG Capsulotomy (Right, Left)	Other: _____

Social History

Do you smoke? Yes No Have you ever smoke? Yes No When did you quit? _____

Do you use illicit drugs? Yes No Have you ever? Yes No

Do you drink alcohol? Yes No How many do you consume in a day? _____

Please List All Current Medications or Vitamins including dosage & how often you take them:

_____

_____

_____

Allergies

Please List All Allergies & Reactions:

_____

_____

_____

For patients 65 & older:

Have you had your pneumonia vaccination? _____

Do you have a health care proxy in the event you are unable to make your own medical decisions?

Do you have a living will?

Which statement best reflects your wishes on advanced care recommendations?

__ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

__ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

__ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Current Eye Condition

Are you having a problem? _____Or need eye exam? _____

Approximately how long have you been having this problem? _____

Did this problem start suddenly or was it gradual in onset? _____

Have you had this problem before? _____

Does this problem seem to be related to any other problem that you are experiencing?

_____

Approximately how long has your vision been as bad as it is now? _____

Which eye seems worse? __Right __Left __About the same

Have you had any recent eye injury or eye surgery? _____

Approximately how long has it been since your last eye exam? _____

Who did that exam? _____ How long have you had present glasses? _____

Do you wear contact lenses? _____ Do you sleep in them? _____

Please check the following vision problems, if any, that you are experiencing with glasses/contacts:

__Difficulty reading	__Difficulty driving at night	__Difficulty seeing at a distance
__ Eye pain	__Glare causing blurred vision	__Floaters
__Difficulty sewing/ threading a needle	__ Difficulty seeing to hunt	__Itching
__Seeing halos or streaks around lights	__Burning	__Matted eyes in mornings
__Seeing multiple images	__Tearing in one or both eyes	__Difficulty watching tv
__Eye pain in bright lights	__Vision more blurred in sunshine	
__Flashing lights or a curtain over vision	__Difficulty recognizing people at a distance	
__Difficulty doing jobs or hobbies because of blurred vision		