

Today's Date _____

Patient Name: _____ Birthday: _____

Medical Doctor: _____

Phone _____ Fax _____

Address: _____

Please answer the following questions to the best of your ability.

Please describe your current eye problems: _____

Current Symptoms	Right Eye	Left Eye	How Long	Right Eye	Left Eye	How Long
Pain/Soreness of eye or eyelid				Light Flashes		
Eye or Eyelid redness				Floaters in Vision		
Burning Sensation				Temporary Vision Loss		
Sandy or Gritty feeling				Halos around lights		
Mucous Discharge				Computer Vision Strain		
Foreign body sensation				Headaches A.M. P.M.		
Itching				Reading Difficulty		
Watery Eyes				Weak / Lazy Eye		
Swelling of Eyelid(s)				Eye Misalignment		
Light Sensitivity				Vision Therapy / Exercises		
Blurred Vision				Vision Loss		
Double Vision				Other:		

Medical History / Review of Systems Please Circle Any That Apply

Pregnant	Yes	No	
Seasonal Allergies	Yes	No	
Food Allergies	Yes	No	Please List
High Blood Pressure	Yes	No	Controlled with Medication or Diet
Cardiovascular	Yes	No	Heart Attack Angina Arrhythmia Congestive Failure MVP Chest Pain Shortness of Breath Swelling of Feet / Legs
Neurology	Yes	No	Stroke Seizures Migraine Neuropathy Alzheimer's Bells Palsy Mini Stroke Parkinson's Dizziness Headaches Tremors
Endocrine	Yes	No	Thyroid PCOS Diabetes How Long _____ Last HbA1C _____ Last Blood Sugar _____ Excess Thirst Excessive Urination
Pulmonary	Yes	No	Asthma Emphysema Edema COPD Phlebitis Sleep Apnea C - PAP Used Tuberculosis Pneumonia Bronchitis Wheezing Coughing Shortness of Breath
Genitourinary	Yes	No	Prostate Kidney Disease Kidney Stones UTI Dialysis Pain / Burning with Urination Blood in Urine
Gastroenterology	Yes	No	GERD-reflux IBS Ulcers Hiatal Hernia Diverticulitis Liver / Gallbladder Pancreatitis Crohn's Diarrhea Abdominal Pain
Hematology	Yes	No	Anemia Hepatitis High Cholesterol HIV Sickle Cell Disease Lyme Disease Easy Bruising Prolonged Bleeding
Rheumatology / Skeletal	Yes	No	Arthritis Sjogren's Syndrome Lupus Sarcoidosis Gout Osteoporosis Joint Pain
Psychiatry	Yes	No	Depression Anxiety Bipolar ADHD Schizophrenia Other: _____
Cancer	Yes	No	Skin Breast Prostate Lung Leukemia Other: _____
Integumentary	Yes	No	Lupus Shingles Rosacea Psoriasis Eczema Rash Change in Mole
Constitutional	Yes	No	Weight Gain Weight Loss Fatigue Loss of Appetite
HENT	Yes	No	Hearing Loss Sinusitis Sore Throat Dry Mouth
Developmental	Yes	No	Prematurity Intellectual Disability Other:

Surgical History	Bypass - CABG	Heart Stent	Hernia-Herniorrhaphy
	Tonsillectomy	Prostatectomy	Hysterectomy
	Gallbladder-Cholecystectomy		Appendectomy

Other: _____

Medications - Please provide list if additional space is needed.

Eye Medications

Medication	Strength	Frequency	Medication	Strength	Frequency
			AREDS 2		
			Artificial Tears		
High Ocular Risk Medications	Plaquenil	Sabril	Systemic Steroids	Amiodarone	Flomax
	Cialis	Viagra	Thioridazine		Tamoxifen

Allergies To Medications

No Known Drug Allergies

Most Common Medication Allergies:	Penicillin	Sulfa	Codeine	Neomycin	NSAIDS	Aspirin
Other Medication:						
Symptoms:						

Ocular History

Right Eye Left Eye

Cataracts		
Macular Degeneration		
Glaucoma		
Strabismus / Amblyopia		
Diabetic Retinopathy		
Iritis		
Blepharitis / Dry Eyes		
Melanoma		
Epi - Retinal Membrane / Pucker		
Injury to Eye(s)		
Last Exam Date		

Ocular Surgery History

Right Eye Left Eye Surgeon & Date

Retinal Detachment / Tear			
Cataract Surgery			
Glaucoma Surgery			
Injections			
Eye Muscle			
Lasik / PRK / RK			
Diabetic Laser			
YAG (After Cataract)			
Punctal Plugs			
Corneal			
EyeLid			

Social History

Do you Smoke	Never Smoked	Every Day	Occasional/Social	Former
Do you drink Alcohol	None	1 or 2 Drinks Per Day	Occasional/Social	
Do you have a history of substance abuse	No	Yes	Please explain _____	

Hobbies

Hunting	Fishing	Golf	Cross-Stich	Sewing	Reading
Video games	Number of hours using video devices a day? _____				
Other:	_____				

Family History

Please list the family member for any disease or problem you select

Macular Degeneration _____	Retinal Detachment _____	Glaucoma _____	Optic Nerve Disease _____
Cataracts _____	Strabismus (Eye Muscle) _____	Amblyopia (Weak Vision) _____	
Cancer _____	Diabetes _____	Kidney Disease _____	Adopted _____
High Blood Pressure _____	Heart Disease _____	Lung Disease _____	Rheumatoid Arthritis _____

If wearing contacts:

Right Eye Left Eye

Daily Wear (take out at night)		
Extended Wear (sleep with on)		
Astigmatism		
Multifocal		
Other		
Hours a day worn		
Replacement Schedule	Right Eye	Left Eye
One Day		
Two Weeks		
Monthly		
Yearly		
Other		
Solution used		

Contact Symptoms

Right Eye Left Eye How long

Blurring			
Build Up			
Discomfort			
Itching			
Burning			
Stinging			
Corneal Ulcer History			
End of Day Dryness			

Current Brand of Contacts _____

Interested in Daily Contacts _____

Solution Allergy / Sensitivity Brand(s) _____

Reviewed By: Dr. Keith Sparkman O.D.

Signature: _____

Date _____