Today's Date _____

Patient Name: Date of Birth:

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 MS
Endocrine	**Yes**	**No**	Thyroid PCOS Diabetes How Long _____ Last HbA1C _____ Last Blood Sugar _____ Excess Thirst Excessive Urination
Pulmonary	**Yes**	**No**	Asthma Emphysema Edema COPD 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 Phlebitis 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:			

Over

Medications - Please provide list if additional space is needed.

Medication	Strength	Frequency

Eye Medications

Medication	Strength	Frequency
AREDS 2		
Artificial Tears		

High Ocular Risk Medications Plaquenil Sabril Systemic Steroids Amiodarone Flomax Tamoxifen
Cialis Viagra Thioridazine

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		
Solution Allergy / Sensitivity Brand(s)		

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 _____

Reviewed By: Dr. Keith Sparkman O.D.
Signature: _____
Date