Patient Name:_____ **Sex:** ☐M ☐F **Today's Date:**_____

Primary Care Doctor:_____ **Date of Last Eye Exam:**_____

Reason for today's visit:_____

Allergies: _____ ☐ none

Past Medical History: (if yes, provide details in the space to the right)

☐ Y ☐ N diabetic eye disease
☐ Y ☐ N glaucoma
☐ Y ☐ N macular degeneration
☐ Y ☐ N diabetes
☐ Y ☐ N heart problems
☐ Y ☐ N high blood pressure
☐ Y ☐ N cancer
☐ Y ☐ N lung problems/asthma
☐ Y ☐ N arthritis
☐ Y ☐ N gastrointestinal disease
☐ Y ☐ N stroke
☐ Y ☐ N neurologic problems
☐ Y ☐ N skin problems
☐ Y ☐ N psychiatric problems

Medications:

_____
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Past Surgical History: ☐ none
☐ eye surgery/laser procedures
☐ other (specify):

Family History: ☐ unremarkable
☐ blindness ☐ glaucoma ☐ macular degeneration ☐ strabismus ☐ other_____

Social History:
marital status: _____ ; occupation: _____ ; cigarette smoker: ☐ yes ☐ no

Review of Systems:
(if yes, circle symptoms)
☐ Y ☐ N Constitutional: weight loss, weight gain, fever
☐ Y ☐ N Eyes/Visual: eye pain, decreased vision, double vision, floaters, redness
☐ Y ☐ N HENT: headaches, decreased hearing, cold symptoms
☐ Y ☐ N Cardiac: chest pain, shortness of breath, palpitations
☐ Y ☐ N Respiratory: shortness of breath, wheezing, cough
☐ Y ☐ N Gastrointestinal: nausea, reflux, diarrhea
☐ Y ☐ N Genitourinary: possible pregnancy, incontinence
☐ Y ☐ N Skin: rash, new lesions
☐ Y ☐ N Neurologic: weakness, numbness, tremors
☐ Y ☐ N Heme: easy bleeding/bruising
☐ Y ☐ N Musculoskeletal: arthritis, bone pain, weakness