TODAY'S DATE: _____ CHART ID: _____

NAME: _____

BIRTHDATE: _____ AGE: _____ SEX: _____ RACE: _____

Referring Dr: _____

Primary Care Dr: _____

List any surgeries you have had (Cataract, Tonsils, Appendix, etc.): _____

Are you a new patient? Y or N (Please circle response)

Tech: _____

If "No", has your medical history changed since your last visit? Y or N ? Date of last eye exam: _____

Dr: _____

1. EYES: (Circle ALL That Apply)

Is this Workman's Comp? Y or N

Vision Loss	Mucous Discharge	Excess Tears / Watering
Blurred Vision	Watery Discharge	Light Sensitivity
Fluctuating Vision	Redness	Eye Pain or Soreness
Distorted Vision	Sandy / Gritty Feeling	Lazy or Crossed Eyes
Loss of Side Vision	Itching	Eye or Lid Infection
Double Vision	Burning	Tired Eyes
Dryness	Foreign Body Sensation	Drooping Eyelids

PAST OCULAR HISTORY:
(Circle ALL That Apply)

- Cataract
- Trauma
- Glaucoma
- Macular Degeneration
- Lazy Eye
- Diabetic Retinal Changes

Brief description of your eye problem, when it began, and if it is getting worse, better, or fluctuates: _____

Do you currently have any problems in the following areas?
If "Yes", Please provide information.

2. General (Fever, Weight Loss, etc.)
3. Ear, Nose, Throat (Sinus, Dry Mouth, etc.)
4. Cardiovascular (Heart, Stroke, Blood Pressure, etc.)
5. Respiratory (Asthma, Bronchitis, etc.)
6. Gastrointestinal (Stomach Ulcers, etc.)
7. Genital, Kidneys, Bladder (Prostate, etc.)
8. Muscles, Bones, Joints (Arthritis, etc.)
9. Skin (Warts, Acne, Cancer, etc.)
10. Neurological (Multiple Sclerosis, Tumor, etc.)
11. Psychiatric (Anxiety, Depression, Insomnia, etc.)
12. Endocrine (Diabetes, Thyroid Dysfunction, etc.)
13. Blood / Lymph (High Cholesterol, Anemia, etc.)
14. Allergic / Immunologic (Hay Fever, Lupus, etc.)

Explanation of Problem: _____

FAMILY HISTORY:

Does anyone in your immediate family have any of the following?
(Circle all that apply and list family member)

Blindness	High Blood Pressure
Glaucoma	Kidney Disease
Arthritis	Lupus
Cancer	Stroke
Diabetes	Thyroid Disease
Heart Disease	Other: _____

Explanation of Problem: _____

SOCIAL HISTORY:

Are You: Single Married Widowed Divorced
Employed Retired Other: _____
Occupation: _____

Do You: Smoke or use tobacco products? Y or N
Packs per day or week? _____
Drink alcohol? Y or N
Drinks per day or week? _____

List Medications: _____

List Eye Medications: _____

List Allergic Reaction to Medications: _____