**Date**______________

**Name** ________________________________ **Date of birth** _____________________

**EMAIL**_____________________________________________________________

**Referring physician** ____________________________________________________

**Primary care physician** _________________________________________________

***Reason for visit**: ________________________________________________________

- Are you experiencing any of the following **eye symptoms**? ☐ **Right** ☐ **Left** ☐ **Both**

  ☐ **Blurred reading vision** ☐ **Dryness** ☐ **Tearing** ☐ **Flashes**
  ☐ **Blurred distance vision** ☐ **Double vision** ☐ **Burning** ☐ **Floaters**
  ☐ **Sandy or gritty feeling** ☐ **Halos** ☐ **Glare** ☐ **Itching**
  ☐ **Other** _______________ ☐ **Redness**
- How long have you had these symptoms? _______________

**OCULAR HISTORY**

- Have you ever been diagnosed with an eye problem or had an eye injury? ☐ **No**

If yes, ***when and what type***? ____________________________________

__________________________________________________________

__________________________________________________________

- Have you had any of the following **surgeries**? ☐ **No**

☐ **Cataract surgery** ☐ **Eye muscle surgery** ☐ **Cornea surgery**

☐ **Retina surgery** ☐ **Carotid surgery** ☐ **Brain surgery**

☐ **Heart bypass surgery** ☐ **Heart stents or angioplasty**

☐ Other: _______________________________________________________

______________________________________________________________

**FAMILY HISTORY** Do members of your **immediate family** have **eye/medical problems**? ☐ **No**

**Immediate family= father, mother, sister or brother. Please list relationship.**

☐ **Blindness** ☐ **Diabetes** ☐ **Cataracts**

☐ **Glaucoma** ☐ **Lazy eye** ☐ **Strabismus**

☐ **Retinal disorder** ☐ **Cancer** ☐ **Heart disease**

☐ **Macular degeneration** ☐ **Other** ______________

**PLEASE COMPLETE BOTH FRONT AND BACK FOR INSURANCE BILLING**

## PAST MEDICAL HISTORY

- Are you treated or followed for any **medical conditions**? ☐ **None**

| | | | |
|---|---|---|---|
| ☐ **Arthritis** | ☐ **COPD** | ☐ **High blood pressure** | ☐ **Lupus** |
| ☐ **Asthma** | ☐ **Heart attack** | ☐ **Kidney disease** | ☐ **Rheumatoid Arthritis** |
| ☐ **Atrial fibrillation** | ☐ **Heart disease** | ☐ **Stroke** | ☐ **Multiple Sclerosis** |
| ☐ **Diabetes** | ☐ **Heart failure** | ☐ **Thyroid** | ☐ **Tuberculosis** |
| ☐ **Cancer** | ☐ **High cholesterol** | | |
| **Type:**________________ | | ☐ **Other** ____________________ | |

## SOCIAL HISTORY

- Do you smoke? ☐ **Yes** ☐ **No** If so, **how much**? ______________________
- Have you ever smoked? ☐ **Yes** ☐ **No** If so, **how many years**? ____________

- Please list your **current medications**, including over-the-counter products and vitamin/herbal supplements. ☐ **None**

☐ **See list provided by patient**

____________________________________

____________________________________

____________________________________

____________________________________

____________________________________

**•ALLERGIES TO MEDICATIONS** ☐ **None**

| **DRUG:** | **REACTION:** |
|---|---|
| _______________ | _________________ |
| _______________ | _________________ |

**Have you ever taken:**

| | | |
|---|---|---|
| Myambutol (Ethambutol) | ☐ **Y** | ☐ **N** |
| Flomax | ☐ **Y** | ☐ **N** |
| Plaquenil (Hydroxychloroquine) | ☐ **Y** | ☐ **N** |

- Do you experience any of the following **symptoms**? ☐ **No**

| | | |
|---|---|---|
| ☐ **Chills** | ☐ **Tinnitus** (Ringing ears) | ☐ **Cold Sores** |
| ☐ **Dizziness** | ☐ **Chronic cough** | ☐ **Skin Rashes** |
| ☐ **Fevers** | ☐ **Shortness of breath** | ☐ **Headaches** |
| ☐ **Night sweats** | ☐ **Abdominal pain** | ☐ **Numbness or tingling** |
| ☐ **Unintentional weight loss** | ☐ **Blood in stool** | ☐ **Mood problems** |
| ☐ **Chest pain** | ☐ **Diarrhea** | ☐ **Excessive thirst** |
| ☐ **Edema** (Swelling of legs) | ☐ **Blood in urine** | ☐ **Heat or cold intolerance** |
| ☐ **Palpitations** | ☐ **Painful urination** | ☐ **Easy bruising** |
| ☐ **Nosebleeds** | ☐ **Warm, red joints** | ☐ **Sneezing and itchy nose** |
| ☐ **Sore throat** | | |

- I hereby assign to the physician(s) all payments for services rendered to myself or my dependents.
- I understand that I am responsible for any amount not covered by insurance.
- I permit a photocopy of my signature to be used in place of the original for this purpose.

______________________________________ ______________

Patient or legal guardian signature Date