

Ophthalmology

NAME: _____ **Age:** _____ **Today's Date:** _____

Family Physician/Internist: _____ **Date of last visit:** _____

Optometrist: _____ **Date of last visit:** _____

Referred by: _____ **Relationship:** _____

Eye History:

- 1. Do you wear glasses? Yes _____ No _____
- 2. Do you wear contact lenses? Yes _____ No _____
- 3. Do you have problems reading with glasses? Yes _____ No _____
- 4. How does your eye condition affect your daily activities? _____

5. Have you ever had an eye injury or eye surgery? Please describe:

Personal Medical History: Please **circle** and **date** those that you have now and in the past:

- | | | |
|-----------------------|---------------------------|------------------------|
| Anemia _____ | Gout _____ | Liver Disease _____ |
| Transfusions _____ | Arthritis _____ | Heart Disease _____ |
| Lung Disease _____ | Tuberculosis _____ | Asthma _____ |
| Hepatitis _____ | Migraines _____ | Ulcers _____ |
| Cancer _____ | High Blood Pressure _____ | Seizures _____ |
| Other _____ | Colitis _____ | High Cholesterol _____ |
| Stroke _____ | Diabetes _____ | Kidney Disease _____ |
| Thyroid Disease _____ | | |

Past Surgical History: Please **list** and **date** any surgeries you have had.

Are you currently taking any **Medications**? Yes _____ NO _____ If yes, please list below.

Are you allergic to any **Medications or Dyes**? Yes _____ NO _____ If yes, please list below.

Family Medical History: Please **circle** and **list** family relationship- **Blood relative only**

Glaucoma _____ Retinal Disease _____ Macular degeneration _____
Diabetes _____

Please give a brief statement as to the health status of the following:

Parents: _____

Brothers/Sisters: _____

Children: _____

Social History:

If employed, how many hours do you work per week? _____

If retired, former occupation? _____

Do you smoke? Yes _____ No _____ If so, how much? _____

Education: _____ If you are a student, name of school _____ What grade? _____

Review of Recent Symptoms: Please circle either yes or no.

Constitutional:

unusual fatigue yes/no
excessive thirst yes/no
swollen glands yes/no
weight change yes/no

Urinary:

pain or burning yes/no
urinary frequency yes/no
penile discharge yes/no
blood in urine yes/no

Neurologic:

muscle weakness yes/no
numbness/tingling yes/no
seizures/convulsions yes/no
loss of balance yes/no

Ears, Nose, Throat, Mouth:

hearing loss yes/no
bleeding gums yes/no
hoarseness yes/no
sore throat yes/no

Bones & Joints:

painful or stiff joints yes/no
swelling in joints yes/no

Gastrointestinal:

hard to swallow yes/no
abdominal pain yes/no
nausea/vomiting yes/no

Heart:

racing/fluttering yes/no
chest discomfort yes/no
swollen feet/ankles yes/no
shortness of breath yes/no

Lungs:

breathing difficulty yes/no
wheeze yes/no
cough yes/no
coughing up blood yes/no

Blood:

easy bruising yes/no
prolonged bleeding yes/no

Mood:

memory change yes/no
depression yes/no

Skin:

rash or hives yes/no
change in skin or moles yes/no

I have seen my internist/family physician for the above problems: Yes _____ No _____

address, also: _____

TO BE FILLED OUT BY THE NURSE:
