Patient name: _____ Date: _____

EYES: DO YOU (the PATIENT) HAVE ANY OF THESE PROBLEMS TODAY?

Macular Degeneration	Discharge	Iritis
Blurred Vision	Double Vision	Itching
Bothersome Night Glare	Dry Eye	Poor Night Vision
Burning	Eye Pain	Redness
Cataract	Eye Strain	Retinal Problems
Conjunctivitis	Floaters	Sensitivity to Light
Diabetes	Glaucoma	Tearing
Diabetic Retinopathy	Headache	Total Loss of Vision

OTHER ORGANS: DO YOU or HAVE YOU had ANY OF THESE CONDITIONS?

Constitution:	**Cardiovascular:**	**GU:**	**Integ:**	**Psych:**
Developmental Disabilities	High Blood Pressure	Kidney Disease	Eczema	Depression
Cancer	Heart Attack	Prostate Cancer	Rosacea	Attention Deficit
Fatigue Syndrome	Stroke	Benign Prostate	Psoriasis	Anxiety Disorder
ENT:	Heart Disease	Pregnant	Cold Sores	Bipolar
Hearing Loss	Vascular Disease	Nursing	Shingles	**GI:**
Sinusitis	**Respiratory:**	Herpes	**Endo:**	Crohn's
Dry Mouth	Cigarette Smoker	Chlamydia	Type 1 Diabetes	Colitis
Laryngitis	Asthma	Other STDs	Type 2 Diabetes	Ulcer
Neuro:	Bronchitis	**Musc/Skel:**	Last A1C _____	Acid Reflux
Multiple Sclerosis	Emphysema	Arthritis	Thyroid Dysfunction	Celiac Disease
Epilepsy	COPD	Osteoarthritis	Hormonal Dysfunction	**Heme/Lymph:**
Cerebral Palsy	Sleep Apnea	Fibromyalgia		Anemia
Brain Tumor	**Allergies:Immune**	Muscular Dystrophy		High Cholesterol
Migraine	Environmental Allergies	Ankylosing Spondylitis		Bleeding Ulcer
Migraine	Rheumatoid Arthritis	Osteoporosis		
	Lupus			
	Sjogren's Syndrome			

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HAVE YOU EVER BEEN TOLD YOU HAVE:

___Glaucoma/ Glaucoma suspect ___Cataracts ___Macular Degeneration ___Retinal Problems

___Any Eye or Lid Surgery ___Lazy Eye ___Diabetic Eye Problems ___Other _____

DO YOU USE: ___Alcohol ___Tobacco LIST YOUR HOBBIES: _____

MEDICATIONS YOU TAKE (include Eye Drops): _____

MEDICATIONS YOU ARE ALLERGIC TO:_____

THINGS THAT RUN IN THE FAMILY: (father, mother, brother, sister)

___Arthritis	f m b s	___Lazy Eye (Amblyopia)	f m b s
___Cancer	f m b s	___Cataract	f m b s
___Diabetes	f m b s	___Macular Degeneration	f m b s
___High Blood Pressure	f m b s	___Glaucoma	f m b s
___Heart Disease	f m b s	___Retinal Detachment	f m b s
___Thyroid Disease	f m b s	___Crossed Eye (Strabismus)	f m b s

WHO IS YOUR PRIMARY CARE PHYSICIAN? _____