Name

PATIENT HISTORY AND INFORMATION

PRIMARY CARE PHYSICIAN

Primary Care Physician and Clinic Name

Address of Primary Care Physician City State Zip Phone

REFERRING PHYSICIAN

Referring Physician and Clinic Name

Address of Referring Physician City State Zip Phone

HEALTH HISTORY

What is the main reason for today's exam ? _____ When was your last exam ? _____

When was your last health exam ? _____

Past Illnesses or Injuries: _____ _____

Past Surgeries: _____ _____

Current Medications: _____ _____

_____ _____

Current Eye Drops: _____ _____

_____ _____

Medicines that cause reactions or sensitivities: _____

Specific Allergies: _____

EYE HISTORY

Glaucoma	O Yes O No	Dryness	O Yes O No	Strabismus (Crossed Eyes)	O Yes O No
Cataract	O Yes O No	Excess Tearing/Watering	O Yes O No	Blurred Vision Distance	O Yes O No
Macular Degeneration	O Yes O No	Eye Pain or Soreness	O Yes O No	Blurred Vision Near	O Yes O No
Retinal Detachment	O Yes O No	Foreign Body Sensation	O Yes O No	Distorted Vision (halos)	O Yes O No
Color Blindness	O Yes O No	Infection of Eye or Lid	O Yes O No	Double Vision	O Yes O No
Headaches	O Yes O No	Itching	O Yes O No	Floaters or Spots	O Yes O No
Glare/Light Sensitivity	O Yes O No	Mucous Discharge	O Yes O No	Fluctuating Vision	O Yes O No
Tired Eyes	O Yes O No	Drooping Eyelid	O Yes O No	Loss of Vision	O Yes O No
Amblyopia (Lazy Eye)	O Yes O No	Redness	O Yes O No	Loss of Side Vision	O Yes O No
Burning	O Yes O No	Sandy or Gritty Feeling	O Yes O No		

GENERAL HEALTH CONDITION

Fever	O Yes O No	Respiratory (Asthma)	O Yes O No	Anxiety or Depression	O Yes O No
Weight Loss	O Yes O No	Gastrointestinal	O Yes O No	Thyroid, Diabetes	O Yes O No
Other Symptoms	O Yes O No	Kidney	O Yes O No	Blood/Lymph	O Yes O No
Ears,Nose,Throat	O Yes O No	Muscles,Bones,Joints	O Yes O No	Allergic	O Yes O No
Cardiovascular (high blood pressure etc.)	O Yes O No	Skin	O Yes O No	Are you?	☐ Pregnant ☐ Nursing
		Neurological (Multiple Sclerosis)	O Yes O No		

FAMILY HISTORY

Amblyopia (Lazy Eye)	O Yes O No	Retinal Detachment	O Yes O No	High Blood Pressure	O Yes O No
Blindness	O Yes O No	Strabismus (Eye Turn)	O Yes O No	Kidney Disease	O Yes O No
Cataract(s)	O Yes O No	Arthritis	O Yes O No	Lupus	O Yes O No
Color Blindness	O Yes O No	Cancer	O Yes O No	Stroke	O Yes O No
Glaucoma	O Yes O No	Diabetes	O Yes O No	Thyroid Disease	O Yes O No
Macular Degeneration	O Yes O No	Heart Disease	O Yes O No	Others	O Yes O No