

Eye Doctors Seen:

Have you ever had an eye injury? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please describe injures and date: \_\_\_\_\_

Have you ever had any previous eye surgery or laser? YES \_\_\_\_\_ NO \_\_\_\_\_ If yes, please give name of operation and dates: \_\_\_\_\_

What other operations have you had? Please give types and dates: \_\_\_\_\_

<i>Are you currently having problems with any of the following:</i>	<i>Circle One</i>		<i>Specific problem or give details</i>
	YES	NO	
Unexplained weight gain or loss greater than 10 lbs.			
Fever, Chill, Night Sweats			
Decreased vision, eye pain, double vision			
Decreased hearing, ringing in ears			
Nasal congestion, nose bleeds, sinus congestion			
Hoarse voice, sore throat			
Chest pains or heaviness, shortness of breath, leg pain when walking, ankle swelling, irregular heartbeat			
Cough, wheezing, coughing up blood or sputum			
Heartburn, nausea, stomach pain, diarrhea, constipation			
Problems with kidneys, urination, bladder			
Skin rashes or lesions, breast lumps			
Headaches, dizziness, muscle weakness			
Joint Pain, stiffness, swelling			
Depression, nervousness/anxiety			
Lymph node swelling, infections			
Itching, sneezing / allergy symptoms			

Are you a smoker? YES \_\_\_\_\_ NO \_\_\_\_\_ #Cigarettes per Day \_\_\_\_\_ When did you stop? \_\_\_\_\_  
 Alcohol Use: None \_\_\_\_\_ Social \_\_\_\_\_ 2-3x/week \_\_\_\_\_ with dinner \_\_\_\_\_ Other \_\_\_\_\_  
 Occupation \_\_\_\_\_ Live alone: YES \_\_\_\_\_ NO \_\_\_\_\_  
 Exercise: None \_\_\_\_\_ Occasionally \_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_  
 Do you Drive? YES \_\_\_\_\_ NO \_\_\_\_\_

<i>Among your blood relatives, is there any history of any of the following:</i>	<i>Circle One</i>		<i>Mother, Father, Sister, Brother</i>
	YES	NO	
Glaucoma			
Cataracts			
"Lazy Eye" or Muscle Imbalance			
Retinal Disease or Macular Disease			
Migraine			
Night Blindness/Color Blindness			
Unexplained Vision Loss			
Diabetes Mellitus			
Tumor or Cancer			
High Blood Pressure			
Heart Disease			
Bleeding Disorder			
If Applicable, Are you pregnant?			

Nurse/Tech/MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_