Race:

☐ African American	☐ Native Hawaiian or Other Pacific Islander
☐ Asian	☐ Native American or Alaska Native
☐ Caucasian	☐ Other

Language:

☐ English ☐ Spanish ☐ Other

Ethnicity:

☐ Hispanic or Latino ☐ Not Hispanic or Latino

Reason for Visit: _____

ARE YOU HAVING ANY OF THE FOLLOWING CONCERNS?		
Blurred Vision	☐ Yes	☐ No
Eyestrain	☐ Yes	☐ No
Eye Pain	☐ Yes	☐ No
Severe Sensitivity to Lights	☐ Yes	☐ No
Headache	☐ Yes	☐ No
Poor Night Vision	☐ Yes	☐ No
Bothersome Night Glare	☐ Yes	☐ No
Double Vision	☐ Yes	☐ No
Total Loss of Vision	☐ Yes	☐ No
Redness	☐ Yes	☐ No
Burning	☐ Yes	☐ No
Itching	☐ Yes	☐ No
Tearing	☐ Yes	☐ No
Discharge	☐ Yes	☐ No

HAVE YOU EVER BEEN DIAGNOSED WITH THE FOLLOWING EYE CONDITIONS?		
Cataract	☐ Yes	☐ No
Age Related Macular Degeneration	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Diabetic Retinopathy	☐ Yes	☐ No
Dry Eye	☐ Yes	☐ No
Eye Infection, Inflammation, or Allergy	☐ Yes	☐ No
Floaters and/or Flashes of Light	☐ Yes	☐ No
Iritis or Uveitis	☐ Yes	☐ No
Retina Defects or degenerations	☐ Yes	☐ No
Please list any additional conditions:		

Medical History: (Please mark all that apply.)

Constitutional		
Developmental Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Fatigue Syndrome	☐ Yes	☐ No

Ear, Nose, Throat		
Hearing Loss	☐ Yes	☐ No
Sinusitis	☐ Yes	☐ No
Dry Mouth	☐ Yes	☐ No
Laryngitis	☐ Yes	☐ No

Neurological		
Multiple Sclerosis	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No
Tumor	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Migraine	☐ Yes	☐ No

Psychiatric		
Depression	☐ Yes	☐ No
Attention Deficit	☐ Yes	☐ No
Anxiety Disorder	☐ Yes	☐ No
Bipolar Disorder	☐ Yes	☐ No

Cardiovascular		
Hypertension	☐ Yes	☐ No
Stroke/CVA	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Vascular Disease	☐ Yes	☐ No
Congestive Heart Failure	☐ Yes	☐ No

Respiratory		
Cigarette Smoker	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No
Chronic Obstruction	☐ Yes	☐ No
Sleep Apnea	☐ Yes	☐ No

Gastrointestinal		
Crohn's	☐ Yes	☐ No
Colitis	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Acid Reflux	☐ Yes	☐ No
Celiac Disease	☐ Yes	☐ No

Genitourinary		
Kidney Disease	☐ Yes	☐ No
Prostate disease	☐ Yes	☐ No
STD herpetic/ chlamydia	☐ Yes	☐ No
Benign Prostate Hypertrophy	☐ Yes	☐ No
Pregnant	☐ Yes	☐ No
Nursing	☐ Yes	☐ No

Musculoskeletal		
Arthritis	☐ Yes	☐ No
Osteoarthritis	☐ Yes	☐ No
Fibromyalgia	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Ankylosing Spondylitis	☐ Yes	☐ No
Osteoporosis	☐ Yes	☐ No
Gout	☐ Yes	☐ No

Integumentary		
Eczema	☐ Yes	☐ No
Rosacea	☐ Yes	☐ No
Psoriasis	☐ Yes	☐ No
Herpes Simplex/Cold Sores	☐ Yes	☐ No
Herpes Zoster/ Shingles	☐ Yes	☐ No

Endocrine		
Type 1 Diabetes Mellitus	☐ Yes	☐ No
Type 2 Diabetes Mellitus	☐ Yes	☐ No
Thyroid Dysfunction	☐ Yes	☐ No
Hormonal Dysfunction	☐ Yes	☐ No

Hematologic/Lymphatic		
Anemia	☐ Yes	☐ No
Ulcer	☐ Yes	☐ No
Hyper-cholesterolemia	☐ Yes	☐ No

Family Ocular History:

(Limit to Parents, Siblings, Offspring)

			Relationship to patient:
Amblyopia (Lazy Eyes)	☐ Yes	☐ No	
Blindness	☐ Yes	☐ No	
Cataracts	☐ Yes	☐ No	
Color Blindness	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	

			Relationship to patient:
Macular Degeneration	☐ Yes	☐ No	
Retinal Detachment	☐ Yes	☐ No	
Strabismus (Eye Turn)	☐ Yes	☐ No	
Others:	☐ Yes	☐ No	

Family Medical History:

			Relationship to patient:
Arthritis	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Heart Disease	☐ Yes	☐ No	
High Blood Pressure	☐ Yes	☐ No	
Kidney Disease	☐ Yes	☐ No	

			Relationship to patient:
Lupus	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Others:	☐ Yes	☐ No	

Current Medications (With Dosage):

_____

_____

Medication Allergies: _____

Other Allergies: _____

Social History:

Do you drink alcohol? If yes, how much/often? ☐ No ☐ Occasional ☐ 1 Per Day ☐ 2-3/day ☐ 4+/day

Tobacco use: ☐ No ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless Tobacco ☐ Other _____

Smoking status: ☐ Never Smoker ☐ Current Every Day ☐ Current Some Days ☐ Former Smoker

Hobbies: _____

Vitals:

Height: _____ft. ____in ☐ Decline to answer.

Weight: _____ lbs. ☐ Decline to answer.

Contact Lens History:

Do you currently wear contact lenses: ☐ Yes ☐ No Since_____

Type and brand of contact lenses: _____

Today's wearing time: _____ How many days/week? _____ How many hours a day? _____