MEDICAL HISTORY AND REVIEW OF SYSTEMS

Name ____________________

Family Physician ____________________

Date of Birth ____________________

Date of last eye exam ________________

Today's Visit is for:

☐ Evaluation for a complaint (billed to medical insurance)

☐ Routine evaluation, no complaints, "I just want a new pair of glasses", (most billed to vision insurance)

Review of Systems Please answer yes or no for each question

	Yes	No		Yes	No		Yes	No
Fever	☐	☐	Chest Pain	☐	☐	Stomach/Intestine Pain	☐	☐
Sinusitis	☐	☐	Headaches	☐	☐	Increased Urination and/or Thirst	☐	☐
Rash	☐	☐	Joint Pain	☐	☐	Shortness of Breath	☐	☐

Eyes

	Yes	No		Yes	No		Yes	No
Halos	☐	☐	Dry Eyes	☐	☐	Refractive Surgery	☐	☐
Burning	☐	☐	Itching	☐	☐	Double Vision	☐	☐
Tearing	☐	☐	Redness	☐	☐	Loss of Side Vision	☐	☐
Pain	☐	☐	Discharge	☐	☐	Protruding Eyes	☐	☐
Flashes	☐	☐	Floaters	☐	☐	Crossed Eyes	☐	☐
Glare	☐	☐	Blurred Vision	☐	☐			

Other ______________________________ I wear ☐ Glasses ☐ Contacts

Past Medical History

	Yes	No		
Eye Disease	☐	☐	Describe	______________________________
Eye Surgery	☐	☐	Describe	______________________________
Other Surgery			Describe	______________________________
Diabetes	☐	☐	Type 1 or Type 2	Last Blood Glucose Level ____________________
Insulin Use	☐	☐	Last A1c __________	Date ____________________

PCP or Endocrinologist Fax# ______________________________

	Yes	No		Yes	No		Yes	No
Asthma	☐	☐	Rheumatoid Arthritis	☐	☐	Irregular/Fast Heart Beat	☐	☐
Cancer	☐	☐	Sleep Apnea	☐	☐	Anemia or Blood Disorder	☐	☐
Heart Attack	☐	☐	High Cholesterol	☐	☐	Congestive Heart Failure	☐	☐
Seizure	☐	☐	High Blood Pressure	☐	☐	**Enlarged Prostate**	☐	☐
Emphysema	☐	☐	Thyroid Disease	☐	☐	**Flomax/Like Medications**	☐	☐

Other medical problems

Describe ____

Current Medications include all Herbal and Over-the-Counter Medications as well as dosage information and route of administration (mouth, injection, cream, or suppository) ______________________________

____

____

Drug Allergies Please list. ____

Reaction ____

Family History Yes No

Has anyone in your family (Parents, Sister, or Brother) had a serious eye problem? ☐ ☐

Explain ____

Tobacco Use Current use? ☐Yes ☐No Former user? ☐ Yes ☐ No

Alcohol Use ☐ Yes ☐ No Frequency ________ Substance Abuse ☐ Yes ☐ No

Do you still Drive ☐ Yes ☐ No

Living Condition ☐With Family ☐Alone ☐Nursing Home ☐Retirement Center ☐Caretaker

Physician Signature______________________________________Date______________