

Name: _____ Date _____

1 Please describe any concern or problems you have with your eyes: _____

Cont: _____

2 Do you wear : glasses? contact lens?
 3 Date of last eye exam? and Doctor?
 Date: _____ Doctor: _____

10 Please give the following for the last three times you have been hospitalized. (except normal pregnancies)
 Reason for hospitalization _____ Month/Yr. _____

4 Please check any of the problems you have with your vision or sight.
 disturbance in clarity
 blurred
 decrease in night vision
 glare or streaks around lights
 halos around lights
 sees flashes of light
 spots before your eyes
 trouble identifying colors
 double vision
 Other _____

11 List anything you are allergic to, including medicines.

5 Please list any of the problems you have with your eyes.
 red or bloodshot
 itching or burning sensation
 eyes water a lot
 discharge or pus
 sensitive to light
 gritty sensation
 other (please name) _____

| 12 Review of Systems | | |
|-----------------------|-----------------------|----------------------------|
| No | Yes | Comments |
| <input type="radio"/> | <input type="radio"/> | Neurological _____ |
| <input type="radio"/> | <input type="radio"/> | Head Trauma _____ |
| <input type="radio"/> | <input type="radio"/> | Ears, Nose, Throat _____ |
| <input type="radio"/> | <input type="radio"/> | Respiratory _____ |
| <input type="radio"/> | <input type="radio"/> | Cardiovascular _____ |
| <input type="radio"/> | <input type="radio"/> | Hypertension _____ |
| <input type="radio"/> | <input type="radio"/> | Gastrointestinal _____ |
| <input type="radio"/> | <input type="radio"/> | Genitourinary _____ |
| <input type="radio"/> | <input type="radio"/> | Hematologic/Lymph _____ |
| <input type="radio"/> | <input type="radio"/> | Endocrine _____ |
| <input type="radio"/> | <input type="radio"/> | Diabetes _____ |
| <input type="radio"/> | <input type="radio"/> | Musculoskeletal _____ |
| <input type="radio"/> | <input type="radio"/> | Skin _____ |
| <input type="radio"/> | <input type="radio"/> | Cancer _____ |
| <input type="radio"/> | <input type="radio"/> | Infectious Disease _____ |
| <input type="radio"/> | <input type="radio"/> | Immunologic/Allergic _____ |
| <input type="radio"/> | <input type="radio"/> | Psychiatric _____ |

6 Please check or describe problems with your eyelids.
 eyelids itch or burn
 stick together in the morning
 red and swollen eyelids
 other (please describe) _____

13 Please indicate if you or any blood Relatives have had any of the following conditions.

7 Have you ever had eye surgery?
 Yes No If yes, please describe

| You | Relative | |
|-----------------------|-----------------------|----------------------|
| <input type="radio"/> | <input type="radio"/> | AIDS |
| <input type="radio"/> | <input type="radio"/> | lupus/collagen dis. |
| <input type="radio"/> | <input type="radio"/> | hepatitis |
| <input type="radio"/> | <input type="radio"/> | emphysema/asthma |
| <input type="radio"/> | <input type="radio"/> | diabetes or 'sugar' |
| <input type="radio"/> | <input type="radio"/> | high blood press. |
| <input type="radio"/> | <input type="radio"/> | heart condition |
| <input type="radio"/> | <input type="radio"/> | thyroid or arthritis |
| <input type="radio"/> | <input type="radio"/> | cancer or tumor |
| <input type="radio"/> | <input type="radio"/> | blindness |
| <input type="radio"/> | <input type="radio"/> | glaucoma |
| <input type="radio"/> | <input type="radio"/> | retinal detachment |
| <input type="radio"/> | <input type="radio"/> | cigarette smoker |

8 Have you had any eye injury?
 Yes No If yes, please describe

9 List all medication you are currently taking, including eye drops, birth control pills, and medications you buy without a prescription.

