Patient Name: _____ Date of Birth: _____ Date: _____

This questionnaire to be reviewed at each appointment. Please answer all questions.

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary/Family Doctor: _____ Date of last visit: _____

Are you Pregnant? _____ Nursing? _____ Recently pregnant? _____ If yes- how long ago? _____.

How is your General Health? _____

Review of Systems: Medical History

*Please circle yes or no if **you** have or have had any of these symptoms. If YES please list medication taken.*

Allergies	Yes/No	Medication: _____
Respiratory	Yes/No	Medication: _____
Cholesterol	Yes/No	Medication: _____
Ear/Nose/Throat	Yes/No	Medication: _____
Thyroid	Yes/No	Medication: _____
Mental	Yes/No	Medication: _____
Heart	Yes/No	Medication: _____
High Blood Pressure	Yes/No	Medication: _____
Headaches	Yes/No	Medication: _____
Migraines	Yes/No	Medication: _____
Nervous	Yes/No	Medication: _____
Gastrointestinal	Yes/No	Medication: _____
Cardiovascular	Yes/No	Medication: _____
Urinary	Yes/No	Medication: _____
Muscles/Bones	Yes/No	Medication: _____
Skin	Yes/No	Medication: _____
Endocrine (glands)	Yes/No	Medication: _____
Blood/Lymph	Yes/No	Medication: _____
Diabetes	Yes/No	Type1/Type 2 Date of Diagnosis: _____ Medication: _____
Cancer	Yes/No	Type: _____ Date of Diagnosis: _____

Are you allergic to any medication or Latex? If yes please list type: _____

Other Health Problems?: _____

Medication Not Listed above: _____

Operations: Yes/No Kind: _____ Date:_____

Family History

High Blood Pressure	Yes/No	Relation: _____	Macular Degeneraton	Yes/No	Relation: _____
Diabetes	Yes/No	Relation: _____	Retinal Detachment	Yes/No	Relation: _____
Glaucoma	Yes/No	Relation: _____	Cataracts	Yes/No	Relation: _____
Blindness	Yes/No	Relation: _____			

Personal Eye Information

Are you being treated by another physician for any eye disease? YES/NO Physician: _____

Do you have any eye conditions or problems? Yes/No What Kind?_____

Have you had any eye operations? Yes/No Type: _____ Date: _____

Have you had an eye injury? Yes/No Kind: _____ Date: _____

*Please circle yes or no if **you** have or have had any of these symptoms. If YES please list medication taken.*

Glaucoma	Yes/No	Medication: _____
Macular Degeneration	Yes/No	Medication: _____
Cataracts	Yes/No	Medication: _____
Retinal Detachment	Yes/No	Medication: _____
Dry Eyes	Yes/No	Medication: _____
Allergy Eyes	Yes/No	Medication: _____

Blindness	Yes/No	Lazy Eye	Yes/No	Color Blind	Yes/No	Blurred Vision Yes/No	Eye Strain yes/No
Flashes	Yes/No	Floaters	Yes/No	Pain	Yes/No	Discharge Yes/No	Redness Yes/No

Social History

Do you or have you used Tobacco products? Yes/No Type: _____ Usage: _____

Do you or have your used Illegal drugs? Yes/No Do you consume Alcohol? Regularly/often/rarely/never

Does you occupation expose you to chemicals? Yes/No

Have you been exposed to sexually transmitted disease(s) Yes/No

Please sign below indicating you have reviewed the above information and made changes as applicable

Date: _____ PatientGuardian Signature: _____

Date: _____ Patient/Guardian Signature: _____

Date: _____ Patient/Guardian Signature: _____

Date: _____ Patient/Guardian Signature: _____

Date: _____ Patient/Guardian Signature: _____

Reviewed by/Date