Patient Name ____ **Today's Date** _____________________________

1) Please state your reason for today's visit:

____

____

2) EYE HISTORY *** Do you currently wear eyeglasses? Y / N** *** Do you currently wear contact lenses? Y / N**

* Please √ check the box next to each condition to inform the doctor if have/had any of the eye conditions listed:

Eye or Vision Disorder	□ NONE	□ glaucoma □ macular degeneration □ cataract □ strabismus □ amblyopia □ other ____________________
Eye Surgery	□ NONE	□ specify type of surgery and date of surgery ____________________
Eye Injury	□ NONE	□ specify injuries ____________________

3) Smoking History □ Never Smoked □ Former Smoker □ Current Smoker ______________________________

4) FAMILY HISTORY □ NONE

□ Glaucoma Mom, Dad, Sibling? ________________________

□ Macular Degeneration Mom, Dad, Sibling? ________________________

□ Other ____

5) REVIEW OF SYSTEMS/HEALTH

* Please √ check the box next to each organ system to inform the doctor if you have/had any of the conditions listed:

Ear, Nose, Throat	□ NONE	□ Hearing Loss □ Chronic Sinusitis □ Dry Mouth □ Other________________________
Neuro	□ NONE	□ Multiple Sclerosis (MS) □ Migraine □ Concussion □ Parkinson's Dis □Alzheimer's Dis □ Epilepsy □ Cerebral Palsy (CP) □ Stroke □ other ________________________
Psych	□ NONE	□ Anxiety □ Depression □ Bipolar □ Post-Traumatic Stress □ other ________________
Cardiovascular:	□ NONE	□ High Blood Pressure □ High Cholesterol □ Heart Disease □ other ________________
Respiratory	□ NONE	□ COPD □ Asthma □ Sleep Apnea □ other ________________________
Gastro-Intestinal	□ NONE	□ Acid Reflux □ Crohn's □ Colitis □ other ________________________
Musculo-Skeletal	□ NONE	□ Arthritis □ Connective tissue disease □ other ________________________
Skin	□ NONE	□ Eczema □ Psoriasis □ Basal Cell Carcinoma □ other ________________________
Endocrine	□ NONE	□ Type 1 Diabetes □ Type 2 Diabetes □ Thyroid Dysfunction □ other ________
Blood & Lymph	□ NONE	□ Anemia □ Leukemia □ other________________________
Allergy & Immune	□ NONE	□ Environmental Allergies □ Rheumatoid Arthritis □ Lupus________________________
Cancer	□ NONE	□ Lymphoma □ Breast Cancer □ Prostate Cancer □ other ________________________
Other	□ NONE	□ Autism □ behavioral disorder □ learning disability □ other ______________________

6) MEDICATIONS □ NONE □ Please list ANY medications that you use regularly (include pills, injections, eye drops):

____

____

7) Do you have any allergies to medications? Yes / No Please list: ____

I acknowledge the above information is complete, true, and correct ____

Patient or Guardian SIGNATURE

v. 2019-02-28 Cicero Family Eye Care