

PHOENIXVILLE EYE CARE SPECIALISTS P.C.

NAME _____ **DATE** _____

Reason for today's visit _____

| <u>OCULAR HISTORY</u> | YES | NO |
|------------------------------------------|------------|---------------|
| Cataracts | _____ | _____ |
| Glaucoma (pressure in the eye) | _____ | _____ |
| Lazy eye (amblyopia) | _____ | _____ |
| Retinal detachment | _____ | _____ |
| Macular degeneration | _____ | _____ |
| Diabetic retinopathy | _____ | _____ |
| Other Eye Problems, please explain _____ | | |
| Any eye surgeries _____ | | |
| Date of surgery _____ | | Surgeon _____ |

OTHER MEDICAL CONDITIONS SIGNIFICANT TO OCULAR

(Please check all that apply)

| | | |
|----------------------------|----------------------------------|----------------------------------|
| _____ Anemia | _____ Rheumatoid Arth. | _____ Asthma/COPD |
| _____ Breast CA | _____ CVA/Carotid/Stroke | _____ Diabetes |
| _____ Heart Disease | _____ Hrt Valve/Pacemaker | _____ High Blood Pressure |
| _____ HIV/Hepatitis | _____ Lupus | _____ Lyme |
| _____ MERSA | _____ MS | _____ Rosacea |
| _____ Sarcoid | _____ Sleep Apnea | _____ Thyroid |

| <u>MEDICAL HISTORY (ROS)</u> | YES | NO | EXPLANATION |
|---------------------------------------------------------|------------|-----------|--------------------|
| Constitutional (fever, weight loss) | _____ | _____ | _____ |
| Integumentary (skin, breast) | _____ | _____ | _____ |
| Ear, nose, and throat | _____ | _____ | _____ |
| Respiratory (lungs, breathing) | _____ | _____ | _____ |
| Cardiovascular (heart, circ., BP, hrt val/pace) | _____ | _____ | _____ |
| Gastrointestinal (stomach, intestines) | _____ | _____ | _____ |
| Genitourinary (prostate, kidney) | _____ | _____ | _____ |
| Musculoskeletal (joints, rheumatoid arth.) | _____ | _____ | _____ |
| Neurological (stroke, MS) | _____ | _____ | _____ |
| Endocrine (diabetes , thyroid, Graves) | _____ | _____ | _____ |
| Hematologic/Lymphatic (anemia) | _____ | _____ | _____ |
| Psychiatric | _____ | _____ | _____ |
| Allergic/Immunologic (lupus) | _____ | _____ | _____ |
| Infectious diseases (HIV/hepatitis) | _____ | _____ | _____ |
| Any head/eye trauma | _____ | _____ | _____ |
| General surgeries | _____ | _____ | _____ |

FAMILY HISTORY

Has any blood relative ever had:

| | YES | NO | RELATIONSHIP |
|----------------------|------------|-----------|---------------------|
| Diabetes | _____ | _____ | _____ |
| Glaucoma | _____ | _____ | _____ |
| Cataracts | _____ | _____ | _____ |
| Lazy eye | _____ | _____ | _____ |
| Macular degeneration | _____ | _____ | _____ |
| Blindness | _____ | _____ | _____ |
| Other eye problems | _____ | _____ | _____ |
| Explanation | _____ | | |

ALLERGIES

REACTION

SEVERITY

| | | | |
|-------|------|----------|--------|
| _____ | mild | moderate | severe |
| _____ | mild | moderate | severe |
| _____ | mild | moderate | severe |

CURRENT MEDICATIONS

DOSAGE

FREQUENCY

REASON

| | | | |
|-------|-------|-------|-------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

SOCIAL HISTORY

HOW MUCH-HOW OFTEN-FOR HOW LONG

Do you:

| | | | |
|-------------|-------|-------|-------|
| Use Alcohol | _____ | _____ | _____ |
| Smoke | _____ | _____ | _____ |

OCCUPATION

PRIMARY PHYSICIAN

ANY EYE SPECIALISTS YOU ARE SEEING

PHARMACY NAME

PHARMACY ADDRESS
