PHOENIXVILLE EYE CARE SPECIALISTS P.C.

NAME_____ **DATE**_____

Reason for today's visit_____

OCULAR HISTORY	**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**

MEDICAL HISTORY (ROS)	**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 _____