

HEALTH HISTORY

What is the reason for seeking treatment today? If having any problems, describe:

Circle all that apply: blind spots, blinking, blurring, bulging eye, bump, burning, crossed eye, crusting, dark curtain, decreased vision, difficulty driving, difficulty reading, difficulty with distance, discharge, distorted vision, double vision, droopy eyelids, dryness, eyelid, eye strain, floaters, foreign body sensation, glare, growth, halos, headaches, irritation, itching, lazy eye, light flashes, light sensitivity, migraines, pain, poor color vision, poor depth perception, poor night vision, poor side vision, protruding, pupils, redness, small eye, swelling, tearing, twitching

Where is your problem located?

When did your symptoms start?

Have your symptoms remained the same, worsened or improved?

Is there anything that changes symptoms?

Are your symptoms constant, intermittent or infrequent?

How severe are your symptoms on a level from 1-10?

Do you wear glasses?

Y/N

Do you wear contacts?

Y/N If so, what kind?

Have you tried contacts unsuccessfully?

Y/N

Do you have any history of eye problems?

Y/N If yes, describe:

Circle all that apply: allergies, blepharitis, blindness, cataracts, corneal disease, diabetic retinopathy, dry eyes, glaucoma, high eye pressure, infections, macular degeneration, macular membrane, narrow angle glaucoma, ophthalmic migraines, retinal tear, retinal detachment, strabismus, vitreous detachment, vitreous floaters, vitreous hemorrhage, other

Have you had any surgery or injuries to your eyes?

Y/N If yes please describe:

Circle all that apply: blepharoplasty, cataract, corneal, eyelid, eye muscle, intravitreal injections, LASIK, laser, PRK, punctal plugs, retinal, RK, other

Are you taking any eye medications or drops?

Y/N If yes, describe:

What is your main pharmacy and where is it located?

Are you allergic to any eye medications or drops?

Y/N If yes, describe:

Who is your medical doctor?

City located?

Do you have any medical problems?

Y/N If yes describe:

Circle all that apply: AIDS, anemia, arthritis, asthma, autoimmune disease, birth defect, blood disorder, bronchitis, cancer, childhood disease, colitis, connective tissue disorder, COPD/emphysema, diabetes, heart disease, high blood pressure, high cholesterol, HIV+, irregular heartbeat, kidney disease, liver disease, migraines, neurologic disease, poor circulation, prostate problems, reflux, seizures, sickle cell, sinusitis, steroid use, stroke, TB, thyroid, ulcers, other

Have you ever been hospitalized? Y/N If yes, describe:

Have you had any non-ocular surgeries? Y/N If yes, describe:

Are you taking any medications? Y/N If yes, describe:

Are you allergic to any drugs or other products? Y/N If yes, describe:

Is there a family history of eye or medical diseases? Y/N If yes, describe:

Circle all that apply: blindness, cancer, cataract, diabetes, glaucoma, heart disease, hypertension, migraine, retinal detachment, strabismus, other

Age

Occupation

Marital Status

Do you drive?

Y/N

Have you had any recent travel outside of the Continental USA?

Y/N

Do you smoke?

Y/N

If yes, how many packs/day?

Have you ever smoked?

Y/N

Do you drink alcohol?

Y/N

If yes, how many drinks/day?

Do you use any street drugs?

Y/N

If yes, describe:

Are you sexually active?

Y/N

Do you have any problems with: Circle all that apply: If none to all, circle: **No to all**

Allergies

hay fever, hives

Heart

chest pain, rapid heart rate

General Health

chills, fever, weight gain, weight loss

Endocrine

cold/heat intolerance, excessive urination/thirst

Ears, Nose, Mouth

cough, discharge, dry mouth, ear pain, hearing loss, pain, stuffy nose

Gastrointestinal

constipation, diarrhea, nausea, vomiting

Genitourinary

blood, burning, increased frequency, incontinence

Blood/Lymph

bleeding, swelling, transfusions

Skin

bumps, changing moles, ulcers, rash, scalp tenderness

Muscle/Joint

pain, stiffness, swelling

Neurologic

dizziness, headache, imbalance, numbness, poor memory, weakness, confusion

Psychiatry

anxiety, depression, insomnia

Respiratory

congestion, shortness of breath, wheezing

Please answer the following questions: If none to all, circle: **No to all**

Are you allergic to adhesive?

Y/N

Are you allergic to lidocaine?

Y/N

Are you taking any blood thinners?

Y/N

Do you have a defibrillator?

Y/N

Are you taking Flomax?

Y/N

Do you have a pacemaker?

Y/N

Do you get rapid heart beat with epinephrine?

Y/N

Are you pregnant?

Y/N

Do you have any symptoms of Covid-19 virus or exposure to it

Y/N