NAME: _____ DATE: _____

DO YOU HAVE ANY OF THE FOLLOWING?

EYES	YES	NO
Decreased vision		
Blind spots in vision		
Double/multiple images		
Floating objects		
Flashing lights		
Lazy or wandering eye		
Poor color vision		
Light sensitivity		
Itchy eyes		
Dry and scratchy eyes		
Eye pressure		
Eye pain		
Eye mattering/Discharge		
Excessive tearing		
Eye surgeries		
Eye injuries		
Droopy eyelid		
Other:		

ALLERGIES

(Please include all food, eye-drop, medication, or environmental.)

ALCOHOL

Drinks per day:

TOBACCO

Cigarettes per day:

CONSTITUTIONAL	YES	NO
Fevers/Chills		
Weight loss/Gain		
Nausea/Vomiting		
EAR/NOSE/THROAT		
Sinus problems		
Hearing loss		
NEUROLOGICAL		
Headaches/Tingling/Seizures		
DERMATOLOGICAL		
Skin rash/Dry skin		
CARDIOVASCULAR		
High blood pressure		
Heart disease/Heart attack		
Irregular heartbeat		
ENDOCRINE		
Diabetes		
Thyroid disease		
RESPIRATORY		
Lung disease/Asthma		
Shortness of breath		
MUSCOLOSKELETAL		
Joint pain/Swelling		
Other:		

FAMILY HISTORY

Cataracts
Glaucoma
Diabetes
Macular Degeneration
Blindness (any cause)
Other:

CURRENT MEDICATIONS

(Please include all eye-drops, prescription, over-the-counter, and dietary supplements.)

SIGNATURE _____ **All above reviewed and no changes** ☐