WELCOME TO THE EYE CENTER! Today's Date: _____ / _____/ _____

PLEASE COMPLETE THE FOLLOWING:

Chosen Name (last, first): _____ Date of Birth: _____ / _____/ _____

Legal Name (if different than chosen): _____ Height: _____ ft _____ in Weight:_____ lbs

Pronouns: ☐ he/him ☐ she/her ☐ they/them ☐ _____

Last EYE Doctor/Location: _____ Date of last EYE exam: _____

Primary Care Physician/Location: _____ Date of last PHYSICAL Exam: _____

Pharmacy/Location_____ Occupation: _____

SPECTACLE/CONTACT LENSES

Do you wear glasses? ☐ Yes ☐ No ☐ Full Time ☐ Part Time ☐ Distance Only ☐ Reading Only ☐ Multifocal

How old are your current glasses? _____

Do you wear contact lenses? ☐Yes ☐No Are you interested in a new contact lens design? ☐ Yes ☐ No

COMPUTER USE How many total hours per day do you use a computer, cell phone, tablet or play video games?
☐ 0-2 hours ☐ 2-4 hours ☐ 4-6 hours ☐ more than 6 hours

Do you use computer glasses? ☐ Yes ☐ No Are you interested in special glasses to make computer work easier? ☐ Yes

SPORTS AND LEISURE : What sports/hobbies do you participate in? _____

Do you wear any special eyewear for your sport/hobby? _____

Do you currently wear prescription sunglasses? ☐ Yes ☐ No Are you sensitive to bright lights? ☐ Yes ☐ No

_____

What is the **MAIN reason** for your visit today? _____

Do you have any other visual/eye problems? _____

REVIEW OF SYSTEMS ***Are you currently experiencing any of the following symptoms?***

☐ Please check here if ALL of review of systems is NO

Category	Current Symptoms	Yes	Category	Current Symptoms	Yes	Category	Current Symptoms	Yes
Constitutional	Fever		***Genitourinary***	Burning while urinating		***Musculoskeletal***	Unexplained muscle pain	
	Unexplained Weight Loss			Difficulty urinating			Joint pain/restricted movement	
	Unexplained Fatigue			Blood in urine			Lower back pain	
Cardiovascular	Chest pain		***Head***	Sore throat		***Neurologic***	Muscle weakness	
	Difficulties with exertion			Hearing loss			Tingling in extremities	
	Irregular heart beat			Hoarse voice			Dizziness	
Endocrine	Increased urination			Loss of smell			Dimming of vision	
	Increased thirst			Sinus congestion		***Psychiatric***	Ongoing depression	
	Increased appetite		***Hematologic/ Lymphatic***	Swollen glands			Memory lapses	
Gastrointestinal	Constipation			Easy bruising			Disorientation	
	Diarrhea		***Integumentary (Skin)***	Unexplained skin rashes		***Respiratory***	Shortness of breath	
	Blood in stool			Itching of skin			Persistent cough	
				Pigmented areas			Wheezing sounds	

PLEASE TURN OVER →

MEDICATIONS

Please include all medications, including inhalers, contraceptives and over the counter

Medication Name	Purpose	Dose	Medication Name	Purpose	Dose
Over-the-counter/Topical			**Eye drops**		

Are you *currently* on or have *previously* taken either of the following medications:

Tamsulosin (Flomax) ☐ YES ☐ NO.

Hydroxychloroquine (Plaquenil) ☐ YES ☐ NO **If Yes** - current dose: _____

PLEASE CHECK ONLY THOSE BOXES THAT APPLY. UNCHECKED BOXES WILL MEAN "NO".

EYE HISTORY

Condition	Self	Family	
	Yes	Yes	Relation
Eye Turn/Strabismus/Lazy Eye			
Childhood cataracts			
Glaucoma/Suspect			
Macular Degeneration			
Retinal tear/detachment			
Dry Eye			
Previous Eye Injury			
Other Eye Conditions(s):			
Previous Eye Injection		**Type of Injection:**	
LASIK/Refractive Surgery		**Type of surgery:**	
Previous Eye Surgery		**Type of surgery:**	
Elective or other facial procedures		**Type of surgery/procedure:**	

SOCIAL HISTORY

	Yes
Drink alcohol	
Smoked in the past	
Currently smoke	Type
Recreational drug use	Type

REPRODUCTIVE HEALTH

	Yes
Pregnant - currently	
Nursing - currently	

ALLERGIES

	Yes
Seasonal	
Medication(s)	
Other	

MEDICAL HISTORY

Condition	Self	Family	
	Yes	Yes	Relation
Diabetes			
High blood pressure			
Elevated Cholesterol			
Heart disease/heart attack			
Sleep Apnea			
Migraine			
Thyroid disorder			
Stroke			
Cancer Type(s):			
Asthma/COPD			
Kidney disease			
Arthritis, Type(s):			
History of COVID-19 infection		Date of infection(s):	
Other:			

I verify that the information contained on this page is current.

_____

Patient Signature

_____

Date