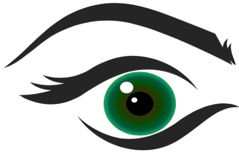

# COMPLETE PRIMARY EYECARE

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. Thank you for your cooperation.

**DATE:** ______________________

**PATIENT NAME:** ____________________________________________________________ **D.O.B.** ______________________

**LIST ANY MEDICATIONS YOU CURRENTLY TAKE** (OR ATTACH LIST): ____________________________________________________

________________________________________________________________________________________________________

**MEDICATION ALLERGIES:** (PLEASE LIST THE MEDICATION AND TYPE OF REACTION**)** ________________________________________

________________________________________________________________________________________________________

**LIST ALL MAJOR ILLNESSES OR INJURIES:** (EX: DIABETES, HIGH BLOOD PRESSURE, STROKE, HEART ATTACK, GLAUCOMA, ETC.)

________________________________________________________________________________________________________

**LIST ANY SURGERIES YOU HAVE HAD:** (EX: CATARACT, JOINT REPLACEMENT, APPENDECTOMY) ______________________________

________________________________________________________________________________________________________

**DATE OF LAST EYE EXAM:** _______________________ **DO YOU WEAR GLASSES? Y / N HOW OLD ARE THEY:** _______

**DO YOU WEAR CONTACT LENSES? Y / N IF YES, WHAT TYPE:** _______________________________________________

**<u>FAMILY HISTORY:</u>** HAS ANY FAMLY MEMBER (PARENTS, SIBLINGS, GRANDPARENTS) HAD ANY OF THE FOLLOWING CONDITIONS?

DIABETES: Y / N RELATIONSHIP: _____________________ HIGH BLOOD PRESSURE: Y / N RELATIONSHIP: _________________

STROKE: Y / N RELATIONSHIP: _____________________ GLAUCOMA: Y / N RELATIONSHIP: _____________________

BLINDNESS: Y / N RELATIONSHIP: _____________________ RETINAL DETACHMENT: Y / N RELATIONSHIP: __________________

MACULAR DEGENERATION: Y / N RELATIONSHIP: _____________________ CATARACT: Y / N RELATIONSHIP:_______________

**<u>PERSONAL SOCIAL HISTORY:</u>** PLEASE NOTE, THIS INFORMATION IS KEPT STRICTLY CONFIDENTIAL. HOWEVER, YOU MAY DISCUSS THIS PORTION DIRECTLY WITH YOUR DOCTOR IF YOU PREFER: YES, I PREFER TO DISCUSS THIS PORTION WITH MY DOCTOR

**OCCUPATION, IF EMPLOYED:** ______________________________________________ **DO YOU DRIVE? Y / N**
**IF YES, ANY DIFFICULTY WHEN DRIVING? Y / N PLEASE EXPLAIN ANY DIFFICULTY:** ______________________________________

**DO YOU USE TOBACCO PRODUCTS? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG?** ______________________________

**DO YOU DRINK ALCOHOL? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG?** _____________________________________

**DO YOU USE ILLICIT DRUGS, INCLUDING MARIJUANA? Y / N IF YES, TYPE/AMOUNT/FOR HOW LONG?** ________________

________________________________________________________________________________________________________

In each area, if you are not having any difficulties, please check "No Problems." If you are **CURRENTLY** experiencing any of the symptoms listed, **please circle the ones that apply,** or explain any that may not be listed. If you have any questions about this, please ask one of the technicians.

**CONSTITUTIONAL (General Health)** ❑ No Problems, Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ____________
______________________________________________________________________________________

**EYES:** ❑ No Problems, Loss of vision, blurred vision, distorted vision/ halos, double vision, pain, tearing, redness, light sensitivity, mucous discharge. Other: ____________________________________________________________

**ENT:** ❑ No Problems, Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________________________

**CARDIOVASCULAR** ❑ No Problems, Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________________________________________________________

**RESPIRATORY** ❑ No Problems, Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ___________________
______________________________________________________________________________________

**GASTROINTESTINAL** ❑ No Problems, Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence.
Other: ________________________________________________________________________________

**GENITOURINARY** ❑ No Problems, Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence, pregnant, breastfeeding. Other: _________________________________________________________

**MUSCULOSKELETAL** ❑ No Problems, Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ________________________________________________________________________

**INTEGUMENTARY. (Skin, Hair & Breast)** ❑ No Problems, Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: _____________________________________________

**NEUROLOGICAL** ❑ No Problems, Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other:
______________________________________________________________________________________

**PSYCHIATRIC** ❑ No Problems, Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: __________________________________________________________

**ENDOCRINOLOGICAL** ❑ No Problems, Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: _______________________________________________

**HEMATOLOGICAL** ❑ No Problems, Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ____________________________________________________________________

**IMMUNOLOGIC** ❑ No Problems, Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV or other sexually transmitted diseases. Other:_____________________________________________________

PHYSICIAN'S SIGNATURE: ________________________________________ DATE: __________________