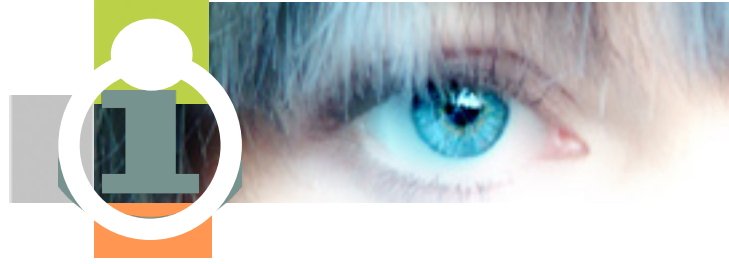




Name	Age
Today's Date	
What is your main reason for today's visit?	
How did you find out about our clinic or who referred you?	
Please list any medications you are allergic to:	
Please list all medications you are currently taking (including eyedrops):	

What kind of medical problems do you have? Please select Yes or No from the Menu.

Yes	No	
Yes	No	Being Treated for high blood pressure
Yes	No	Chest pains or history of heart attack
Yes	No	Stroke or mini-stroke
Yes	No	Carotid surgery
Yes	No	Diabetes
Yes	No	High cholesterol
Yes	No	Rheumatoid arthritis
Yes	No	History of blood clots
Yes	No	Are you on Flomax for your prostate
Yes	No	Migraine headaches
Yes	No	Thyroid disease



Yes	No	
Yes	No	Hepatitis
Yes	No	HIV or Syphilis
Yes	No	Ulcerative colitis or Crohn's disease
Yes	No	Polymyalgia rheumatica
Yes	No	Atrial fibrillation or heart arrhythmia
Yes	No	Fever blisters in mouth
Yes	No	Tuberculosis
Yes	No	Other, Please explain below

Eye History

Yes	No	Lazy eye (amblyopia)
Yes	No	Glaucoma
Yes	No	Cataract
Yes	No	Cataract surgery
Yes	No	Macular degeneration
Yes	No	Retinitis pigmentosa
Yes	No	Diabetic changes in the retina
Yes	No	History of eye injury
Yes	No	Eye laser surgery
Yes	No	Surgery for crossed eyes
Yes	No	Glaucoma surgery
Yes	No	Lasik surgery
Yes	No	Temporal arteritis or Polymyalgia rheumatica
Yes	No	Other, please explain below

Surgery in the past?

Yes	No	Heart bypass surgery
Yes	No	Heart stent
Yes	No	Carotid artery surgery
Yes	No	Hear valve surgery
Yes	No	Vascular surgery
Yes	No	Knee surgery
Yes	No	Hip surgery
Yes	No	Hysterectomy

Yes	No	
Yes	No	Brain surgery
Yes	No	Cancer surgery
Yes	No	Malignant hyperthermia (you or your family)
Yes	No	Problems with past anesthesia
Yes	No	Keloid formation (raised scars with surgery)
Yes	No	Pacemaker and/or defibrillator
Yes	No	Other, please explain below

Does your immediate family (father, mother, brother, sister or children) have any of the following?

Yes	No	Cancer
Yes	No	Diabetes
Yes	No	Heart disease
Yes	No	Arthritis
Yes	No	TB or Syphilis
Yes	No	Cataract
Yes	No	Glaucoma
Yes	No	Retinitis pigmentosa
Yes	No	Macular degeneration
Yes	No	Crossed eyes
Yes	No	Other diseases, please explain below

Social History

Yes	No	Do you have pets at home?
Yes	No	Do you smoke?
Yes	No	Are you a former smoker?
Yes	No	Do you drink alcohol?
Yes	No	Are you retired?
Yes	No	Married
Yes	No	Widowed
Yes	No	Recent travel outside the United States
Yes	No	IV drug use

General

Yes	No	Any recent weight loss
Yes	No	Any fever
Yes	No	Chronically feeling tired
Yes	No	Swollen lymph glands
Yes	No	History of blood transfusion

Head and Neck

Yes	No	Frequent nosebleed
Yes	No	Headaches, especially in the temples
Yes	No	Sores in mouth or nose
Yes	No	Hearing loss

Chest

Yes	No	Chronic cough
Yes	No	Shortness of breath
Yes	No	Coughing up blood

Heart

Yes	No	Chest pains or tightness or pressure
Yes	No	Arm or neck pain or tightness
Yes	No	Shortness of breath when lying flat
Yes	No	Swelling of the ankles
Yes	No	Cramping in the legs when walking
Yes	No	Heart skipping beats or fainting spells

GI (Gastrointestinal)

Yes	No	Blood in the stool or black stools
Yes	No	Chronic diarrhea
Yes	No	Jaundice (yellowing of the skin)

Joint

Yes	No	Chronic joint pain
Yes	No	Hand stiffness, especially in the morning
Yes	No	Neck stiffness
Yes	No	Swelling of the joints
Yes	No	Lower back pain

Genitourinary

Yes	No	Burning with urination
Yes	No	Blood in the urine
Yes	No	History of kidney stones

Skin

Yes	No	Rash
Yes	No	Eyelid lesion or moles
Yes	No	Sensitivity to sunlight

Neuro

Yes	No	Slurring of speech
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Yes	No	Arm or leg weakness on one side
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Infectious

Yes	No	Recent tick bites or Lyme disease
Yes	No	Chronic or unusual infections in the past

Eye

Yes	No	Double vision
Yes	No	Temporal floaters
Yes	No	New floaters
Yes	No	Flashes of light
Yes	No	Blurred vision
Yes	No	Temporary loss of sight
Yes	No	Glare with lights
Yes	No	Trouble reading
Yes	No	Trouble seeing television
Yes	No	Trouble sewing
Yes	No	Eye pain
Yes	No	Eye itching
Yes	No	Chronic eye redness
Yes	No	Feeling of dryness
Yes	No	Foreign body sensation in eye
Yes	No	Occasional crossing of the eyes
Yes	No	Chronic tearing of the eyes
Yes	No	Drooping of the eyelids
Yes	No	Trouble driving (due to vision issue)
Yes	No	Other, please explain below