VITA PARK EYE ASSOCIATES OPHTHALMOLOGY/ OPTOMETRY

DATE OF EXAM________________________________

To assist your eye doctor, please complete the following as accurately as you can.

Name:______________________________ Birth Date: ____/____/____ Occupation:__________________

Referred by:_______________________________________ Family Doctor: _____________________________

Chief Complaint/Reason for Today's Visit: *Please circle all that apply:*

Glasses	Loss of vision	Watery Eyes	Something in Eye
Contacts	Blurred Vision	Itchy Eyes	Floaters
Light Sensitivity	Double Vision	Gritty/Sandy Eyes	General Exam

Other Problems/Complaints____

Follow up on: Glaucoma Cataracts Macular Degeneration
Diabetes Previous Eye Surgery_____________________________________

Extra testing is required for completing a drivers license form. Does yours expire within the next 90 days? Yes / No ________
tech initials

MEDICAL HISTORY

Please circle "Yes" or "No" if you have ever been diagnosed or are currently being treated for the following conditions: ☐ **No Problems**

Yes/**No** Arthritis **Yes**/**No** Emphysema **Yes**/**No** Migraine Headaches
Yes/**No** Asthma **Yes**/**No** High Blood Pressure **Yes**/**No** Thyroid Disease
Yes/**No** Diabetes **Yes**/**No** High Cholesterol **Yes**/**No** Kidney Disease
Yes/**No** Heart condition (Type_____________________) **Yes**/**No** Cancer (Type__________________)
Yes/**No** Other:____

Please list any surgeries ______________________ year_________ ______________________year___________
you have had. ______________________year_________ ______________________ year___________
☐ **No Surgeries** ______________________year_________ ______________________year___________

FAMILY HISTORY

Is there anyone in your family that has/had any of the following conditions? *Please state relation to you.*

Yes/**No** Diabetes______________________________ **Yes**/**No** Glaucoma__________________________
Yes/**No** Macular Degeneration_________________ **Yes**/**No** Blind from Eye Disease________________

PLEASE TURN THIS FORM OVER AND COMPLETE

VITA PARK EYE ASSOCIATES

OPHTHALMOLOGY/
OPTOMETRY

REVIEW OF SYSTEMS

Please check if you have any problems in the following areas.

IF YOU DON'T HAVE ANY PROBLEMS, please check the box "No Problems" in each section.

Allergies
- ☐ Hay Fever
- ☐ Seasonal Allergies
- ☐ ***No Problems***

Gastrointestinal
- ☐ Heartburn
- ☐ Ulcers
- ☐ ***No Problems***

Musculoskeletal
- ☐ Muscle pain
- ☐ Joint pain
- ☐ ***No Problems***

Genitourinary
- ☐ Kidney Disease
- ☐ Pregnant(women only)
- ☐ ***No Problems***

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heartbeat
- ☐ ***No Problems***

Respiratory
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ ***No Problems***

Ears, Nose, Mouth
- ☐ Dry throat, mouth
- ☐ Sores in nose, mouth
- ☐ ***No Problems***

Hematological
- ☐ Bleeding Disorders
- ☐ Leukemia
- ☐ ***No Problems***

Dermatological
- ☐ Skin Sores
- ☐ Severe Itching
- ☐ ***No Problems***

Neurological
- ☐ Headaches
- ☐ Dizziness
- ☐ ***No Problems***

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ ***No Problems***

Constitutional
- ☐ Fever
- ☐ Weight Loss
- ☐ ***No Problems***

Yes/No Do you smoke? How much?___________

Yes/No Consume Alchohol? How much?___________

Yes/No Did you smoke in the past? Year you quit?_______

Yes/No Chew Tobacco? How much?___________

*Please list the medications you are currently taking (**including eye drops**).*

☐ **I am not taking ANY medications or vitamins.**

☐ Aspirin ________________________________ __________________________

☐ Vitamins/Supplements ________________________________ __________________________

____________________________ ________________________________ __________________________

____________________________ ________________________________ __________________________

____________________________ ________________________________ __________________________

Are you **ALLERGIC** to any medications? **Yes/No** If **YES**, Please list.

Drug:________________________________Reaction:____

Drug:________________________________Reaction:____

Drug:________________________________Reaction:____

Drug:________________________________Reaction:____

For Office Use Only:

Reviewed by Tech on:____________ Reviewed by Doctor on:_____________

Tech Initials:____________ Doctor Initials:_____________

Reviewed by Tech on:____________ Reviewed by Doctor on:_____________

Tech Initials:____________ Doctor Initials:_____________

Changes:____

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