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: _____

Pharmacy: _____

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. What month/year does your license expire? ____/____ _____
Month / Year 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 History of MRSA or C.diff

Yes/No Other:_____

Please list any surgeries you have had.

_____year_____ _____year_____
_____year_____ _____year_____
☐ No Surgeries _____year_____ _____year_____

FAMILY HISTORY

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

Yes/No Diabetes_____ Yes/No Glaucoma_____
Yes/No Macular Degeneration_____ Yes/No Blind from Eye Disease_____

SOCIAL HISTORY

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 TURN THIS FORM OVER AND COMPLETE

REVIEW OF SYSTEMS

Please check if you currently 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)
- ☐ *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*

List ALL Medications you are taking, including Eye Drops, Herbals, Vitamins and OTC drugs:

If you have a CURRENT list, please give to receptionist to copy instead of filling out below:

☐ **Aspirin** ☐ **Medication List Attached** ☐ **I do not take any medications**

Medication Name and Dosage	Taken how often?	Route (circle)	Medication Name and Dosage	Taken how often?	Route(circle)
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________
	___ times a day OR ___ as needed	Oral / Topical Other:________		___ times a day OR ___ as needed	Oral / Topical Other:________

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

Drug:________________ **Reaction:**____________ **Drug:**__________________ **Reaction:**_________________
Drug:________________ **Reaction:**____________ **Drug:**__________________ **Reaction:**_________________

For Office Use Only:

Exam Date:___________ **Reviewed by: Tech**_____ **Dr.** _____ **Changes**______________________________
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