

Chart # _____



Patient Name: _____ Date of Birth: _____

Referring Physician (if applicable): _____

Optometrist: _____ Ophthalmologist: _____

Pharmacy Name: _____ Pharmacy City/State: _____

Primary Care Physician: _____

Allergies: Please circle all that apply.

- | | | | |
|------------------------|-----------------------------|---------------------|-------------------|
| No Know Drug Allergies | Benzalkonium Chloride (BAK) | Keflex (cephalexin) | Penicillin |
| Advil (ibuprofen) | Cipro | Latex | Sulfa |
| Alphagan | Codeine | Naprosyn (naproxen) | Tape |
| Aspirin | Gentamicin | Neomycin | Tobramycin |
| Bacitracin | Iodine (shellfish) | Peanut | Valium (diazepam) |
| Other: _____ | | | |

Medications: Please list medication name and dosages (include over-the-counter medications)

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Current Health Complications: Check below if you are experiencing any of these symptoms currently or have within the past 48 hours.

- | | | | | | |
|--------------------------------------|---------------------------------------|--|------------------------------------|--|--|
| <u>General</u> | <u>HEENT</u> | <u>Respiratory</u> | <u>Gastro/Genitourinary</u> | <u>Neuro/Psychological</u> | <u>Ms/Integ.</u> |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Asthma | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Balance Problems | <input type="checkbox"/> Hives/Rashes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Congestion | <input type="checkbox"/> Cough | <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> Bruising | <input type="checkbox"/> Sinus Issues | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Memory Difficulty | <input type="checkbox"/> Joint Stiffness |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> Wheezing | | <input type="checkbox"/> Emotional Changes | |
| <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Arrhythmia | | <input type="checkbox"/> Hallucinations | |
| <input type="checkbox"/> Weakness | | <input type="checkbox"/> Dyspnea (SOB) | | <input type="checkbox"/> Irritability | |
| <input type="checkbox"/> Bleeding | | | | <input type="checkbox"/> Nervousness | |

Height: _____ Weight: _____

Have you had a fall within the past calendar year? Circle One: Yes No
If yes, how many? ____ Did the fall result in an injury? Circle One: Yes No

Ocular History: Please complete this section to the best of your knowledge.

<u>History of Eye Trauma(s)</u>	<u>Affected Eye</u>	<u>Date</u>	<u>Physician</u>
<u>Past Ocular Procedures (s)</u>	<u>Right, Left, or Both</u>		
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Chronic Health Conditions:

Please check if you have ever been diagnosed with any of the following

- | | | | | |
|---|-----------------------------------|--|---|--|
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> A-Fib | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Migraine/Headache | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Sickle Cell Trait |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Stroke |

Past General Surgeries: Please list any past surgical procedures you have had. (Please list any eye surgeries in the previous section labeled "Ocular History")

Family History: Please include information for immediate, genetically related family members. You may abbreviate: Father (F), Daughter (D), Paternal Uncle (PU), etc.

<u>Condition</u>	<u>Family Member</u>	<u>Condition</u>	<u>Family Member</u>
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Macular Degeneration	_____
<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Retinal detachment	_____
<input type="checkbox"/> Glaucoma	_____		

Social History: Please circle which applies

Smoking Current Former Never

Alcohol Current Former Never

Blood Sugar: Please complete if you are diabetic or pre-diabetic

Last blood sugar reading: _____

Last known A-1C: _____

Date and Estimated Time: _____

Patient Signature: _____ **Date:** _____ **Tech Initials:** _____