

Patient Name: _____

Date of Birth: _____

Referring Doctor: _____

Would you like us to send a report to your doctor? Y N

Family Doctor: _____

If Yes: Physician's Name _____

Pharmacy Name: _____

Physician's Phone Number _____

Physician's Fax Number _____

Pharmacy Phone Number: _____

Ocular History: Have you ever been treated for the following:

- Y N Cataract
- Y N Glaucoma
- Y N Cornea Problem
- Y N Diabetic Eye Disease
- Y N Retinal Tear or Detachment
- Y N Eye Muscle Problems
- Y N Eye Trauma or Injury

Any other eye Problems: _____

Last Eye Exam: _____

Do you wear: Glasses Contact Lenses

Surgical History

Please list all surgeries including eye surgeries and approximate date:

Past Medical History: Have you **EVER** been treated for the following and give approximate date:

- Y N Diabetes _____ years Type _____ Fasting Blood Sugar _____ Hg A1C _____
 - Y N High blood pressure _____ years Average Blood Pressure _____
 - Y N Heart attack / heart disease _____
 - Y N Kidney disease / kidney stone _____
 - Y N Lung disease _____
 - Y N Liver disease _____
 - Y N Thyroid disease _____
 - Y N Neurological disease _____
 - Y N Cancer Type _____ Treatments _____
- _____
- _____
- _____

Social History

Occupation: _____

Marital Status: S M D W Do you live: Alone With Family Y N Do you Drive

Y N Did you ever drink alcohol? If YES: Past Present How much _____

Y N Present Smoker _____ Packs per Day Y N Past Smoker _____ Packs per Day

Allergies: Do you have any food or drug allergies? Y N If yes, please list below:

Review of Systems

Do you **CURRENTLY** have any of the following problems:

Explain:

- Y N Chronic fever, weight loss/gain, fatigue
- Y N Ear/Nose/Throat problems (hearing, sinus, etc.)
- Y N Respiratory problems (shortness of breath, wheezing)
- Y N GI problems (heartburn, abdominal pain, diarrhea)
- Y N Urinary problems (pain, blood in urine, kidney stones)
- Y N Skin problems (rashes, excessive dryness)
- Y N Musculoskeletal problems (aches, joint pain, swollen joints)
- Y N Neurological problems (numbness, headache, stroke)
- Y N Bleeding problems
- Y N Psychiatric problems (depression, anxiety)

Please List All Medications (Including Eye Medications)

Name of Medication & Dose	How I take it	Why I take it	Prescribing Doctor	Date Started
<i>Example: Aspirin (81 mg)</i>	<i>1 pill in the morning</i>	<i>Blood</i>	<i>Dr. White</i>	<i>2005</i>
<input type="checkbox"/> Check here if medication List has been attached				

Family History - Has anyone in your immediate family been treated for the following? (If yes, please indicate relationship)

Y N Diabetes	Y N High Blood Pressure	Y N Heart Disease	Y N Stroke
Y N Cancer Type: _____			
Y N Glaucoma	Y N Macular Degeneration	Y N Retinal Detachment	Y N Blindness

Patient Signature: _____ Date: _____

ROS and HPI Performed by Dr. _____ and Dictated to : _____

