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Eye Doctors Seen \_\_\_\_\_

5. Have you ever had any eye injuries? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe injuries and dates: \_\_\_\_\_

6. Have you ever had any previous eye surgery or laser? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please give name of operations and dates: \_\_\_\_\_

7. What other operations have you had? Please give types and dates: \_\_\_\_\_

8. Are you currently having problems with any of the following: please circle the specific problem or give details

a. Unexplained weight gain or loss greater than 10 lbs .....	Yes _____	No _____	_____
b. Fever, chills, night sweats .....	Yes _____	No _____	_____
c. Decreased vision, eye pain, double vision .....	Yes _____	No _____	_____
d. Decreased hearing, ringing in ears .....	Yes _____	No _____	_____
e. Nasal cogestion, nose bleeds, sinus congestion .....	Yes _____	No _____	_____
f. Hoarse voice, sore throat .....	Yes _____	No _____	_____
g. Chest pains or heaviness, shortness of breath, leg pain when walking, ankle swelling, irregular heartbeat .....	Yes _____	No _____	_____
h. Cough, wheezing, coughing up blood or sputum .....	Yes _____	No _____	_____
i. Heartburn, nausea, stomach pain, diarrhea, constipation .....	Yes _____	No _____	_____
j. Problems with kidneys, urination, bladder .....	Yes _____	No _____	_____
k. Skin rashes or lesions, breast lumps .....	Yes _____	No _____	_____
l. Headaches, dizziness, muscle weakness .....	Yes _____	No _____	_____
m. Joint Pain, stiffness, swelling .....	Yes _____	No _____	_____
n. Depression, nervousness / anxiety .....	Yes _____	No _____	_____
o. Lymph node swelling, infections .....	Yes _____	No _____	_____
p. Itching, sneezing / allergy symptoms .....	Yes _____	No _____	_____

9. a. Are you a smoker: Yes \_\_\_\_\_ No \_\_\_\_\_ #cigarettes per day: \_\_\_\_\_ when did you stop: \_\_\_\_\_  
b. Alcohol use: None \_\_\_\_\_ Social \_\_\_\_\_ 2-3x/week \_\_\_\_\_ with dinner \_\_\_\_\_ other \_\_\_\_\_  
c. Occupation: \_\_\_\_\_ Live Alone: yes \_\_\_\_\_ no \_\_\_\_\_  
d. Exercise: None \_\_\_\_\_ Occasionally \_\_\_\_\_ Weekly \_\_\_\_\_ Daily \_\_\_\_\_  
e. Do you drive: Yes \_\_\_\_\_ No \_\_\_\_\_

10. Among your blood relatives, is there any history of any of the following: *Please list: mother, father, sister, brother*

a. Glaucoma .....	Yes _____	No _____	_____
b. Cataracts .....	Yes _____	No _____	_____
c. "Lazy Eye" or Muscle Imbalance .....	Yes _____	No _____	_____
d. Retinal Disease or Macular Disease .....	Yes _____	No _____	_____
e. Migraine .....	Yes _____	No _____	_____
f. Night Blindness/Color Blindness .....	Yes _____	No _____	_____
g. Unexplained Vision Loss .....	Yes _____	No _____	_____
h. Diabetes Mellitus .....	Yes _____	No _____	_____
i. Tumor or Cancer .....	Yes _____	No _____	_____
j. High Blood Pressure .....	Yes _____	No _____	_____
k. Heart Disease .....	Yes _____	No _____	_____
l. Bleeding Disorder .....	Yes _____	No _____	_____

11. If applicable, Are you pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_  
Nurse/Tech/MD Signature: \_\_\_\_\_ Date: \_\_\_\_\_