CENTER FOR SIGHT

Patient Name: _____ **Today's Date:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female

Referring Physician: _____

Preferred Pharmacy: _____ Phone: _____

Address or Crossroads: _____

Ocular History:

☐ Yes	☐ No	Cataracts	☐ Yes	☐ No	LASIK / Epi-LASEK
☐ Yes	☐ No	Cornea Transplant	☐ Yes	☐ No	Macular Degeneration
☐ Yes	☐ No	Diabetic Retinopathy	☐ Yes	☐ No	Punctal Plugs
☐ Yes	☐ No	Dry Eye Syndrome	☐ Yes	☐ No	Retinal Detachment
☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	YAG Laser

☐ Other: _____

What is the reason for your visit today?

☐ Blurred Vision	RT	LT	☐ Dry Eyes	RT	LT	☐ Itching	RT	LT
☐ Decreased Vision	RT	LT	☐ Flashes	RT	LT	☐ Pain	RT	LT
☐ Discharge	RT	LT	☐ Floaters	RT	LT	☐ Red Eye	RT	LT
☐ Double Vision	RT	LT	☐ Headache	RT	LT	☐ Tearing	RT	LT

☐ Other: _____

Immunization / Vaccination:

☐ Yes ☐ No Influenza Date/s: _____

☐ Yes ☐ No Pneumococcal Date: _____

Surgical History:

☐ Yes	☐ No	Appendectomy	☐ Yes	☐ No	Hemorrhoidectomy
☐ Yes	☐ No	Carotid Endarterectomy	☐ Yes	☐ No	Hysterectomy
☐ Yes	☐ No	Gallbladder	☐ Yes	☐ No	Mastectomy
☐ Yes	☐ No	Heart Bypass	☐ Yes	☐ No	Prostate
☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Skin Cancer Removal

☐ Other: _____

Allergies: ☐ No Known Drug Allergies

Allergy	Type of Reaction

☐ Yes ☐ No Latex Please describe: _____

☐ Yes ☐ No Anesthesia Please describe: _____

CENTER FOR SIGHT

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Family History:

☐ Yes	☐ No	Cataracts	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Diabetes	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Glaucoma	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Macular Degeneration	☐ Mother	☐ Father	☐ Other: _____
☐ Yes	☐ No	Retinal Detachment	☐ Mother	☐ Father	☐ Other: _____
☐ Other: _____			☐ Mother	☐ Father	☐ Other: _____

Social History:

Occupation: _____ ☐ Retired ☐ Disabled ☐ Not Working

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Living Conditions: ☐ Alone ☐ Family ☐ Skilled Nursing ☐ Assisted Living

Hobbies: ☐ Computer ☐ Golf ☐ Reading ☐ Tennis ☐ Sewing / Knitting ☐ Walking
☐ Other: _____

Driving: ☐ Yes ☐ No

Alcohol: ☐ Never ☐ Occasional / Social ☐ 1-2 Drinks / Day ☐ 3-4 Drinks / Day

Smoking / Tobacco: ☐ Never ☐ Former ☐ Light Smoker ☐ Heavy Smoker

Past / Present Medical History:

☐ Yes	☐ No	Abdominal Pain	☐ Yes	☐ No	Hearing Loss
☐ Yes	☐ No	Alzheimer's	☐ Yes	☐ No	Heart Attack: Year _____
☐ Yes	☐ No	Anxiety	☐ Yes	☐ No	High Blood Pressure/Hypertension
☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Irregular Heart Beat
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Autoimmune Disease	☐ Yes	☐ No	Kidney Failure
☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Kidney Stones
☐ Yes	☐ No	Bruises	☐ Yes	☐ No	Migraine
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Nausea
☐ Yes	☐ No	Cardiovascular Disease	☐ Yes	☐ No	Parkinson
☐ Yes	☐ No	Cholesterol	☐ Yes	☐ No	Psoriasis
☐ Yes	☐ No	COPD	☐ Yes	☐ No	Seasonal Allergies
☐ Yes	☐ No	Dementia	☐ Yes	☐ No	Sinus Problems
☐ Yes	☐ No	Depression	☐ Yes	☐ No	Skin Rashes
☐ Yes	☐ No	Diabetes: Type 1 or Type 2	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	Headaches	☐ Yes	☐ No	Stomach Ulcers
☐ Yes	☐ No	Hearing Aides	☐ Yes	☐ No	Thyroid Disease

☐ Other: _____