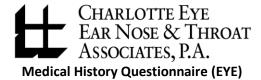


Patient Name:			Today	Today's Date:	
Last		First	companied by:		
Reason for Visit:					
Pharmacy Name:		Pharmacy L	ocation:		
Drug Allergies: 🗆 Yes 🗆 No	If yes, list drug allergie	s and how you reacted:			
List of current medications:					
Surgical History					
Have you had any of the foll	owing procedure? Please cl	neck all that apply.			
Brain Surgery	Cataract Removal/IO	L Implant 🛛 Corneal T	ansplant 🛛 Cosmetic Sur	gery 🛛 Eye Lid Surgery	
🗆 Glaucoma Surgery	Refractive Surgery	🗆 Strabismu	s Surgery 🛛 Laser	🗆 Pterygium	
Tear Duct Surgery	🗆 Retina Surgery				
Comment(s):					
Ocular History					
Have you had or do you curr	ently have any of the follow	ving conditions? Please chec	k all that apply		
🗆 Amblyopia	Bell's Palsy	Cataracts	Corneal Ulcer	Diabetic Retinopathy	
Double Vision	🗆 Eye Trauma	🗆 Glaucoma	🗆 Headache / Migraine	Herpes Zoster	
High Blood Pressure	🗆 Keratitis	Macular Degeneration	ion 🛛 Nystagmus	Optic Atrophy	
Optic Neuritis	Refractive Error	🗆 Retinal Detachmen	t 🛛 Retinal Hemorrhage	🗆 Retinitis Pigmentosa	
Retinoblastoma	Seasonal Allergies	□ Shingles	🗆 Sjogren's Syndrome	Strabismus	
🗆 Unequal Pupil Size	Uveitis				
Comment(s):					
Medical History					
Have you had or do you curr	ently have any of the follow	ving conditions? Please chee	k all that apply.		
□ Acid Reflux	🗆 Anemia	🗆 Aneurysm	🗆 Arthritis	🗆 Asthma	
🗆 Autoimmune Disease	Bleeding Problem	Cancer	Anesthesia Complicat	tions 🛛 COPD	
Diabetes	Hepatitis	Heart Failure	□ HIV/AIDS	🗆 Kidney Disease	
Nerve / Muscle Disease	e 🗆 Sickle Cell Disease	🗆 Stroke			
Comment(s):					
Family History					
Please check any of the follo	wing diseases/conditions th		es have been diagnosed with.		
🗆 Albinism	🗆 Amblyopia	Anesthesia Probler	ns 🛛 Autoimmune Disease	e 🗆 Blindness	
Cancer	Diabetes	Fuchs' Dystrophy	🗆 Glaucoma	Hypertension	
Macular Degeneration	Retinal Detachment	🗆 Strabismus	□ Stroke	Thyroid Disease	
🗆 Unknown					
• •					
Social History					
<u>Tobacco Use</u>					
Current Every Day Smo	ker 🗆 Cur	rent Some Day Smoker	🗆 Never	🗆 Former Smoker	
Passive	🗆 Hea	avy Smoker	🗆 Light Smok	(er	
<u>Smokeless Tobacco Use</u>					
Current User	Never Used	Former User			
Comments on your histor	y with tobacco:				
Alcohol Use: 🗆 Yes 🛛 🗆 No	Drua	<i>Use</i> :□Yes □No			



Review of Systems

Please check all systems which you currently have, or have had recently. If Yes, please explain these symptoms in the comment section. If you have not experienced a medical problem under the symptom listed, please check the No box.

not experienced a meancar problem under the symptom listed, please thete the No box.		
<u>Constitutional Symptoms</u> (ex: fatigue, fever, difficulty sleeping)	🗆 Yes	🗆 No
Comment:		
Gastrointestinal Symptoms (ex: nausea, heartburn, difficulty swallowing)	🗆 Yes	🗆 No
Comment:		
Neurological Symptoms (ex: speech difficulties, migraines, dizziness, headaches, seizures)	🗆 Yes	🗆 No
Comment:		
Integument (Skin) Symptoms (ex: new skin lesions, lumps, change in mole appearance)	🗆 Yes	🗆 No
Comment:		
Genitourinary Symptoms (ex: urgency, pain or burning with urination, kidney stones)	🗆 Yes	□ No
Comment:		
Musculoskeletal Symptoms (ex: muscular weakness, twitching, joint pain)	🗆 Yes	□ No
Comment:		
Head, Ear, Nose, or Throat Symptoms (ex: hearing loss, snoring)	🗆 Yes	□ No
Comment:		
Endocrine Symptoms (ex: weight gain, weight loss, history of thyroid problems)	🗆 Yes	🗆 No
Comment:		
Cardiovascular Symptoms (ex: chest pain, irregular heartbeats)	🗆 Yes	🗆 No
Comment:		
Eve Symptoms (ex: eye discomfort, changes in vision)	🗆 Yes	🗆 No
Comment:		
Respiratory Symptoms (ex: shortness of breath, hoarseness, cough)	🗆 Yes	□ No
Comment:		
Psychiatric Symptoms (ex: anxiety, depression)	🗆 Yes	□ No
Comment:		
Allergic-Immunologic Symptoms (ex: environmental allergies, immune deficiency)	🗆 Yes	□ No
Comment:		
Heme (Blood)-Lymph Symptoms (ex: swollen lymph nodes, easy bleeding or bruising)	🗆 Yes	□ No
Comment:		-

Activities of Daily Living

🗆 Yes

Yes

🗆 Yes

🗆 Yes

Are you deaf or do you have serious difficulty hearing?

🗆 No

Are you blind or do you have serious difficulty seeing, even when wearing glasses?

```
🗆 No
```

Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (5 years old or older)

□ Yes □ No

Do you have serious difficulty walking or climbing stairs? (5 years old or older)

🗆 No

Do you have difficulty dressing or bathing? (5 years old or older)

🗆 No

Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (5 years old or older)

🗆 Yes 🛛 🗆 No

Travel Screening

<u>Have you trave</u>	eled outside the L	J.S. within the last 3 months	<u>;?</u>	
□ Ye	es 🗆	No	If so, where?	