NEVADA EYE CONSULTANTS

PATIENT'S PERSONAL HISTORY - PLEASE COMPLETE ALL INFORMATION. PLEASE PRINT (THANK YOU)

Name_____ **Date**_____

Please check all that apply:		Please check all that apply:	
Headaches		Burning or pain of eyes	
Decreased far vision		Itching of eyes	
Decreased near vision		Mattering of eyes	
Decreased side vision		Distorted vision	
Decreased color vision		Double vision	
Poor driving vision (day)		Recognizing faces of people across the street	
Poor driving vision (night)		"Crossed eyes"	
Difficulty Reading Street Signs		Lazy eye	
Halos around lights		Cataracts	
Glare		Glaucoma	
Sensitivity to light		Macular degeneration	
Floating spots in vision		Difficulty reading	
Flashing lights in vision		Wear glasses	
Redness of eyes		Wear contacts ☐soft ☐hard	
Dryness of eyes		Keloid Scarring	

Review of Systems

Please check Y or N on all:	Y	N	If yes, please explain
Chronic fever, fatigue, unexpected weight gain/loss			
Ear/nose/throat problems (e.g. hearing loss, sinus infection, sore throat)			
Heart problems (e.g. chest pain, irregular heart beat, high blood pressure, cholesterol)			
Respiratory problems (e.g. shortness of breath, wheezing, coughing and asthma)			
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)			
Urinary problems (e.g. pain or discomfort, blood in urine)			
Skin problems (e.g. rashes, excessive dryness)			
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints)			
Neurological problems (e.g. numbness, weakness, headache)			
Psychiatric problems (e.g. depression, anxiety)			
Endocrine problems (e.g. diabetes, thyroid disease)			
Blood problems (e.g. anemia, bleeding tendency)			
Allergies, Hayfever			
Have you ever been exposed to Hepatitis B?			
Have you ever been exposed to Hepatitis C?			
Have you ever tested positive for the HIV Virus?			

please turn the page over to continue

WHAT ARE YOUR VISUAL PROBLEMS & SYMPTOMS?

_____

_____

HAVE YOU EVER BEEN TREATED FOR AN EYE DISEASE OR HAD ANY EYE SURGERY OR EYE INJURY?

YES ☐ **NO** ☐ **IF YES, LIST SYMPTOMS:** _____

LIST ALL MEDICATIONS INCLUDING ANY EYE DROPS YOU TAKE, PRESCRIBED AND OVER THE COUNTER.

(check here _____ if none)

Medicine Name **Condition for Which Medicine is Taken**

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

8) _____

DO YOU HAVE ALLERGIES TO ANY MEDICATIONS OR FOODS? Y N If yes, please list:

_____

_____

_____

LIST ANY HOSPITALIZATIONS, OPERATIONS, MAJOR ILLNESSES

& INJURIES IN THE LAST FIVE YEARS. (check here ____ if none)

1) _____

2) _____

3) _____

4) _____

5) _____

ANSWER EACH:

1) How many packs (per day) of cigarettes do you smoke? **0 1 2 3 more**

2) How many alcoholic drinks (per week) do you drink? **0 1 2 3 5 10 more**

3) Do any medical or eye diseases run in your family (e.g. diabetes, high blood pressure, cataract, glaucoma, macular degeneration)? **Y N** If yes, specify family member with these conditions:

_____

_____

_____

Physician Signature _____ Date _____