

EYE CARE VISION CENTER OF WAUWATOSA

Patient/Family Health History

Patient Name: _____ Last Physical Exam: _____ / _____ Last Eye Exam: _____ / _____
Month / Year Month / Year

Do you have special visual requirements for computers, work (safety glasses), sports (fishing), driving (night) or hobbies? _____

Please list all your current medications (include over the counter, vitamins and herbal therapy): _____

List all major surgeries (including eye and laser surgery): _____

List any allergic reactions to medications or eye drops: _____

Do you wear : Eyeglasses Contact Lenses? Do you have a spare pair of glasses? Yes No Do you have sunglasses? Yes No
 Do you use artificial tears? Yes No WOMEN - Are you pregnant? Yes No Are you breast feeding? Yes No

Please indicate if any of these eye or medical conditions apply to you or a family member (blood relatives only).

Family Member	You	Condition	Relationship	Have you ever had:	
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	_____	<input type="checkbox"/> Burning/Itching/Allergies	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/>	<input type="checkbox"/>	Cataract	_____	<input type="checkbox"/> Crusty, Gritty Feeling	<input type="checkbox"/> Something in Eye
<input type="checkbox"/>	<input type="checkbox"/>	Eye Turn/Strabismus	_____	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Distortion of Vision
<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	_____	<input type="checkbox"/> Droopy Eyelids	<input type="checkbox"/> Dyslexia
<input type="checkbox"/>	<input type="checkbox"/>	Keratoconus	_____	<input type="checkbox"/> Dry Eyes	<input type="checkbox"/> Watery Eyes
<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye/Amblyopia	_____	<input type="checkbox"/> Eye Ache or Pain	<input type="checkbox"/> Pink Eye/Red Eye
<input type="checkbox"/>	<input type="checkbox"/>	Macular Degeneration	_____	<input type="checkbox"/> Flashes of Light	<input type="checkbox"/> Floaters
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	_____	<input type="checkbox"/> Glare/Halos Around Lights	<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/>	<input type="checkbox"/>	Retinal Disease	_____	<input type="checkbox"/> Infection of the Eye or Lid	<input type="checkbox"/> Puffy Lids/ Sties
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	_____	<input type="checkbox"/> Loss of Vision in One Eye	
<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraines	_____	<input type="checkbox"/> Loss of Central/Side/Top/Bottom Vision	
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	_____	<input type="checkbox"/> Mucous Discharge from Eye	
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type _____)	_____	When reading, do:	
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	_____	<input type="checkbox"/> words run together?	<input type="checkbox"/> you lose your place easily?

Review of Systems : Please indicate below if you currently have or have ever had problems with the following conditions or symptoms:

Allergic/Immunologic

- None Lupus Lyme Disease
- Food Allergy Seasonal Allergy
- Environmental Allergy
- Rheumatoid Arthritis
- Autoimmune Disorder /Sjogren's
- Other _____

Ear, Nose and Throat

- None
- Sinusitis
- Ringing in Ears/Tinnitus
- Hearing Loss
- Dry Mouth
- Other _____

Gastrointestinal

- None
- IBD/Colitis/Crohn's
- Acid Reflux/Ulcer
- Liver Disease /Hepatitis
- Other _____

Skin/Integumentary

- None
- Eczema /Psoriasis
- Rosacea
- Herpes Simplex
- Herpes Zoster
- Other _____

Psychiatric

- None
- Anxiety/Depression /Stress
- Bi-Polar
- Schizophrenia
- Panic Episodes
- Other _____

Cardiovascular

- None Stroke Angina
- High Blood Pressure
- Heart Disease Heart Attack
- High Cholesterol
- Vascular Disease
- Other _____

Endocrine/Glands

- None
- Diabetes
- Thyroid Dysfunction
- Other _____

Respiratory

- None Tuberculosis
- Asthma/Bronchitis
- Sleep Apnea
- COPD
- Sarcoid
- Other _____

Muscle/Skeletal

- None
- Arthritis
- Fibromyalgia
- Ankylosing Spondylitis
- Joint/Muscle Pain
- Other _____

Genital/Urinary

- Kidney Disease
- Prostate Disease
- HIV Positive/AIDS
- Herpes/Chlamydia
- Other _____

Hematologic/Lymphatic

- None
- Anemia
- Leukemia /Lymphoma
- Bleeding or Blood Disorder
- Bruise Easily
- Other _____

Neurological

- None Bell's Palsy
- Multiple Sclerosis
- Epilepsy
- Tremors /Seizures/Blackouts
- Migraine
- Other _____

General Health

- Rapid Weight Loss/ Gain
- Fever /Chills
- Fatigue
- Cancer
- Trauma

Social

- Tobacco Use:
 - Current Smoker Former Smoker #/day _____
- Recreational Drugs _____
- Alcohol Consumption _____ oz./day _____
- Exercise: Regularly Occasionally Rarely

Please sign below to acknowledge that this form is current:

Signature: _____ Date: _____ Reviewed by: _____