DATE: _____ **DOB:** _____

NAME: _____

PRIMARY CONCERN / REASON FOR VISIT:

_____

_____

MEDICAL HISTORY AND REVIEW OF SYSTEMS:
Do you presently have, or have you ever been diagnosed with any problems or conditions listed below: **(circle all that apply)**

Yes	No	
☐	☐	**Eye:** cataract, glaucoma, macular degeneration, lazy eye, infections, retinal detachment, iritis
☐	☐	**Head, ears, nose, throat:** *headaches*, cold sores, trouble chewing, jaw pain, trouble swallowing
☐	☐	**Cardiovascular:** *heart attack*, heart failure, *high blood pressure*, pacemaker, atrial fibrillation
☐	☐	**Hematologic:** Anemia, multiple myeloma, bleeding disorders, bone marrow transplant
☐	☐	**Respiratory:** *emphysema*, bronchitis, asthma, *COPD*, tuberculosis, sarcoidosis, sleep apnea
☐	☐	**Gastrointestinal:** *reflux or heartburn*, ulcers, colitis, inflammatory bowel disease, cancer
☐	☐	**Genitourinary:** cancer, kidney stones, bleeding, *Flomax usage*, kidney transplant
☐	☐	**Musculoskeletal:** *osteoarthritis*, Sjögren's, rheumatoid arthritis, lupus, fibromyalgia, other
☐	☐	**Integumentary:** skin cancer, *breast cancer*, dryness, eczema, psoriasis, acne rosacea, rashes
☐	☐	**Neurologic:** *stroke*, numbness, weakness, multiple sclerosis, spine or neck problems
☐	☐	**Endocrine / Metabolic:** *diabetes*, overweight, hypothyroid, hyperthyroid, *high cholesterol*
☐	☐	**Allergic / Immunologic:** *environmental allergies*, hepatitis, HIV, autoimmune disorders
☐	☐	**Mental Health:** anxiety, depression, insomnia, bipolar, eating disorder, claustrophobia

Surgeries or Injuries: (include all eye surgeries)

_____

_____

_____

_____

FAMILY HISTORY: (check and circle all that apply)

- ☐ Heart problems or high blood pressure
- ☐ Thyroid disease or Diabetes
- ☐ Neurologic diseases or Cancer
- ☐ Rheumatoid arthritis or multiple sclerosis
- ☐ Cataracts, Glaucoma or Macular Degeneration
- ☐ Amblyopia, Lazy Eye, or Crossed Eyes
- ☐ Blindness or Color Vision Problems
- ☐ Other: _____

PRIMARY CARE PHYSICIAN:

BRIGHTON VISION CENTER

Name _____

Address _____

City _____ State ___ Zip _____

WHO REFERRED YOU: (if different than above)

Name _____

Address _____

City _____ State ___ Zip _____

DRUG ALLERGIES: _____

_____

MEDICATIONS: (including vitamins, nasal sprays, inhalers, creams)

Medication	Dosage (mg)	Doses Per Day

EYE DROPS OR MEDICATIONS:

VACCINATIONS: **YEAR RECEIVED**

Pneumonia _____

Influenza (Flu) _____

COVID-19 _____

SOCIAL HISTORY:

Occupation: _____

Do you smoke and, if so, how much? _____

If you quit smoking, when did you stop? _____

How much alcohol do you drink? _____

Yes	No	
☐	☐	Do you or have you ever used intravenous drugs?
☐	☐	Do you have trouble with glare or night vision?
☐	☐	Do you have trouble reading or watching TV?
☐	☐	Does your vision limit your ability to drive?
☐	☐	Have you fallen and been injured in the past year?