NORTHERN EYE CARE ASSOCIATES

Name:_____ Date of Birth:_____

Phone Number:_____ Todays Date:_____

Family Doctor:_____ Pharmacy:_____

Please check the boxes of any of the following you are currently experiencing:

Cardiovascular
- ☐ chest pain
- ☐ irregular heart beat
- ☐ shortness of breath

Constitutional
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weakness
- ☐ weight loss

Genitourinary
- ☐ genital discharge
- ☐ genital lesions
- ☐ painful urination
- ☐ urgency

HEENT
- ☐ dizziness
- ☐ hearing loss
- ☐ hoarseness
- ☐ ringing in ears
- ☐ sore throat

Hematologic
- ☐ bleeding
- ☐ bruising
- ☐ tender nodes

Metabolic
- ☐ cold intolerance
- ☐ excess hunger
- ☐ excessive thirst
- ☐ frequent urination
- ☐ heat intolerance

Musculoskeletal
- ☐ back pain
- ☐ joint pain
- ☐ muscle aches
- ☐ stiffness
- ☐ swelling

Neurological
- ☐ balance problems
- ☐ headache
- ☐ numbness
- ☐ tingling

Psychiatric
- ☐ anxiety
- ☐ depression
- ☐ insomnia
- ☐ irritability
- ☐ nervousness

Respiratory
- ☐ cough
- ☐ trouble breathing
- ☐ wheezing

Skin
- ☐ hair loss
- ☐ rash
- ☐ skin lesions

Allergy
- ☐ itching
- ☐ hives
- ☐ chronic runny nose
- ☐ seasonal allergies

Blood Pressure Control
- ☐ good BP control
- ☐ borderline BP control
- ☐ poor BP control
- ☐ unknown BP control
- ☐ Not Applicable

Diabetes Control
- ☐ good DM control
- ☐ borderline DM control
- ☐ poor DM control
- ☐ unknown DM control
- ☐ Not Applicable

Pregnancy/Nursing
- ☐ first trimester
- ☐ second trimester
- ☐ third trimester
- ☐ nursing
- ☐ Not Applicable

Have you been diagnosed with any of the following eye conditions? (Please circle)
Glaucoma Macular Degeneration Diabetic Retinopathy Eye Turn Other:_____

Have you ever had any eye surgeries? Please list the name, approximate date, surgeon and which eye:
_____

Please list all current medications, vitamins and supplements along with the dosage and how often you take them: (If you have a list with you, we can make a copy of it)
_____

Please list any past surgical history along with the approximate date and surgeon:
_____

Please check one of the following: (Tobacco includes Cigarettes, Chew, Cigars, Pipes etc.)
☐ Current Tobacco User ☐ Former Tobacco User ☐ Never Used Tobacco

If you are a current tobacco user please list what type you use and frequency of intake for how many years: _____

Please list any drug, environmental or seasonal allergies: _____

Personal Medical History: (Please check all that apply and write the approximate date of onset)

- ☐ Acid Reflux Disease
- ☐ Alzheimer's Disease
- ☐ Anemia- chronic
- ☐ Arthritis- Degenerative (osteo)
- ☐ Arthritis- Rheumatoid
- ☐ Asthma
- ☐ Atherosclerosis
- ☐ Back pain- chronic
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Brain Tumor- benign
- ☐ Bronchitis- chronic
- ☐ COPD (Chronic Lung Disease)
- ☐ CVA- stroke
- ☐ Cancer- breast
- ☐ Cancer- colon
- ☐ Cancer- lung
- ☐ Cancer- prostate
- ☐ Cancer- skin
- ☐ Cirrhosis
- ☐ Collagen Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ DVT (Deep Vein Thrombosis)
- ☐ Dementia
- ☐ Depression
- ☐ Diabetes- type 1 Last A1C ____
- ☐ Diabetes- type 2 Date _____
- ☐ Dialysis- Hemodialysis
- ☐ Diverticulitis
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Gallstones
- ☐ Gout
- ☐ Graves Disease
- ☐ HIV/AIDS
- ☐ Head injury
- ☐ Headache- chronic
- ☐ Hearing loss
- ☐ Heart attack
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid
- ☐ Irritable Bowel Syndrome
- ☐ Juvenile Chronic Polyarthritis
- ☐ Kidney Stones
- ☐ Leukemia
- ☐ Lupus Erythematous
- ☐ Migraine
- ☐ Multiple Sclerosis
- ☐ Neurofibromatosis
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pain- chronic
- ☐ Peptic Ulcer Disease (PUD)
- ☐ Peripheral Vascular Disease
- ☐ Prostate enlarged (BPH)
- ☐ Psoriasis
- ☐ Renal Insufficiency- chronic
- ☐ Restless Leg Syndrome
- ☐ Rosacea
- ☐ Sarcoidosis
- ☐ Schizophrenia
- ☐ Sicca Syndrome
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea

Family History:
(Check all that apply)

	MOTHER	FATHER	GRANDMOTHER	GRANDFATHER	SON	DAUGHTER	BROTHER	SISTER	NIECE	NEPHEW	AUNT	UNCLE	COUSIN
Amblyopia													
Angle closure glaucoma													
Astigmatism													
Cataract													
Choroidal melanoma													
Corneal dystrophy													
Corneal graft finding													
Diabetic retinopathy													
Glaucoma													
High myopia													
Macular degeneration													
Retinal detachment													
Strabismus													
Anesthetic complications													
Bleeding disorder													
Brain tumor													
Cancer													
Diabetes													
Heart disease													
Hypertension													
Lupus eryuthematosus													
Migraine													
Neurofibromatosis													
Rheumatoid arthritis													
Stroke													
Thyroid disorder													