First:_____**Middle:**_____**Last**:_____

Date of birth _____/_____/_____ **Sex**: Male or Female **SSN**:_____-_____-_____

Spouse/Parent:_____**DOB**:_____/_____/_____**Spouse/Parent Employer**_____

Address:_____**City:**_____**State**:_____**Zip**:_____

Home Phone:_____**Cell**:_____**Work**:_____

Employer/School:_____**Occupation/School Grade**:_____

Sports/Hobbies:_____**E-Mail**:_____

Date of last Medical Exam:_____/_____/_____ **Primary Physician/Clinic**:_____

Date of last Eye Exam:_____/_____/_____ **Pharmacy Name:**_____

Today I would like ☐ Glasses ☐ Contact Lenses ☐ Sunglasses

Visual Symptoms (circle any problems since last exam)

Blur at Distance	Burning Eyes	Floaters/Spots	Headaches
Blur at Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

List all **medical diagnoses** (glaucoma, cataracts, macular degeneration, diabetes, high blood pressure, heart attack, heart disease, cancer, asthma, stroke, thyroid, lupus, AIDS/HIV, depression, eczema, rosacea, kidney disease, STD, crohn's, ADHD, etc.)_____

List any **surgeries** you have had (cataract, appendectomy, etc.):_____

_____

List all current **medications/ dose/ frequency** including over the counter and herbal:_____

_____

_____

List all **allergies**(including drugs,seasonal,food,tape,dye,latex):_____

_____

Review of symptoms *please **circle*** any that apply to you. Use the line below symptom to further explain.

General: Recent- fever ~ chills ~ night sweats ~ weight gain ~ weight loss ~ unusually tired ~ **none**

_____

Skin: dry skin ~ itchy skin ~ rashes ~ bumps ~ sores ~ hair loss ~ sores that don't heal ~ **none**

_____

Pulmonary: shortness of breath ~ chest pain ~ cough ~ coughing up blood ~ wheezing ~ stopped breathing ~ **none**

_____

Cardiovascular: chest pain ~ chest pressure ~ shortness of breath ~ lower extremity edema ~ loss of consciousness ~ rapid pulse ~ irregular heartbeat ~ calf/leg pain ~ wounds/ulcers on feet ~ **none**

_____

Gastrointestinal: heartburn ~ abdominal pain ~ difficulty swallowing ~ pain upon swallowing ~ nausea/vomiting ~ yellowing of skin ~ vomiting blood ~ black stools ~ bloody stools ~ constipation ~ diarrhea ~ **none**

_____

Continue to other side

Review of symptoms continued please **circle** any that apply to you. Use the line below symptom to further explain.

Genito- Urinary: blood in urine ~ burning with urination ~ frequent urination ~ **none**

_____

Hematology/ oncology: fever ~ chills ~ sweats ~ weight loss ~ abnormal bleeding/ bruising
~ growing lumps/ bumps ~ hypercoagulability ~ **none**

_____

Ob/Gyn/Breast: sweats ~ pregnant ~ nursing ~ unusual menstrual cycle ~ **none**

_____

Neurological: loss of neurological function ~ abrupt loss/ change in consciousness ~ numbness ~ weakness
~ dizziness ~ balance problems ~ headaches ~ **none**

_____

Endocrine: fatigue ~ weight loss ~ weight gain ~ **none**

_____

Musculoskeletal: joint pain/ swelling ~ muscle ache ~ low back pain ~ knee pain/ swelling ~ hand symptoms
~ elbow symptoms ~ hip symptoms ~ shoulder pain ~ **none**

_____

Mental Health: sad/ depressed most of the time ~ alcohol or substance abuse ~ anxious ~ agitated
~ memory problems ~ confusion ~ **none**

_____

Sleeping: snore loudly ~ snore quietly ~ wake easily ~ gasp/ stop breathing ~ day fatigue
~ doze/fall asleep when awake ~ **none** Average hours of sleep per night_____hrs.

_____

Social History: Do you drink alcohol? Yes No Amount:_____

Do you smoke? Yes No Quit Amount:_____ How many years?_____

Do you Drive? Yes No Do you have any problems driving? (explain)_____

Special concerns I have about my eyes:_____

Family History

Check if any of your blood relatives (parents, siblings, grandparents) have been diagnosed with inheritable disorders:

Eyes: ☐ Macular Degeneration ☐Glaucoma ☐Blindness ☐Crossed Eye ☐Lazy Eye
others please list:_____

Systemic: ☐Diabetes ☐High Blood Pressure ☐Heart Disease ☐Cancer ☐Thyroid
others please list:_____

I give Dr. Reedy and staff permission to call or send letters/ postcards to my above listed numbers and addresses. I understand that I am responsible for services not covered by insurance. I have seen/refused a copy of privacy practices and I wish to designate _____phone #:_____ as my personal representative/emergency contact.

Sign Here: _____ Date:_____/_____/_____
(patient or guardian)

Reviewed with patient_____O.D.