FAYETTE FAMILY VISION CARE

Patient Name:______________________________Date:__________________

List any **medications** you take (Prescription, Over the Counter, Eye Drops, Birth Control, etc):__________

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List all major **illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc) or **injuries** (concussion, trauma, etc.):

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List any **surgeries** you have had (eye, heart, appendix, knee, etc):__________________

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List any medications you are **allergic** to:______________________________

Please check if you **currently** have problems in the following areas and provide additional information below.

General/Constitution ☐ NONE ☐ fever ☐ weight loss/gain ☐ unusually tired ☐ other
Ears/Nose/Throat ☐ NONE ☐ hard of hearing ☐ ear ache ☐ cough ☐ sore throat ☐ dry mouth ☐ stuffy nose ☐ other
Cardiovascular ☐ NONE ☐ high blood pressure ☐ racing pulse ☐ heart attack ☐ chest pain ☐ stroke ☐ other
Respiratory ☐ NONE ☐ congestion ☐ wheezing ☐ asthma ☐ shortness of breath ☐ bronchitis ☐ emphysema ☐ other
Gastrointestinal ☐ NONE ☐ upset stomach ☐ diarrhea ☐ constipation ☐ hernia ☐ ulcers ☐ heart burn ☐ other
Genital/Kidney/Bladder ☐ NONE ☐ painful/freq urination ☐ kidney disease ☐ prostate disease ☐ STD ☐ other
Muscles/Bones/Joints ☐ NONE ☐ joint pain ☐ stiffness ☐ swelling ☐ cramps ☐ arthritis ☐ other
Allergic/Immunological ☐ NONE ☐ sneezing ☐ swelling ☐ redness ☐ itching ☐ hives ☐ HIV/AIDS ☐ Lupus ☐ other
Blood/Lymph ☐ NONE ☐ bleeding ☐ high cholesterol ☐ anemia ☐ other
Neurological ☐ NONE ☐ numbness ☐ headache ☐ seizures ☐ paralysis ☐ other
Skin ☐ NONE ☐ acne ☐ growths ☐ rash ☐ other **Psychiatric**☐NONE ☐ anxiety ☐ depression ☐ insomnia ☐other
Endocrine ☐ NONE ☐ Diabetes ☐ hypothyroid ☐ other **Females** ☐ NONE ☐ pregnant ☐ nursing

Explain all checks:____

____

DIABETIC Patients: How long have you had Diabetes?__________What was your last blood sugar reading?__________

Date of Last Medical Exam:____________________Name of Primary Care Physician:__________________

*Please check if **you** have ever been diagnosed with any of the following eye problems?* ☐ NONE

☐ Cataracts	☐ Iritis/Uveitis	☐ Retinal/Macular/Cornea Disease
☐ Glaucoma	☐ Dry Eyes	☐ Lazy Eye

Explain checks/OTHER:____

*Please check if any member of your **family** has/had any of these diseases?* ☐ NONE

☐ Blindness	☐ Diabetes	☐ Cancer
☐ Cataracts	☐ High Blood Pressure	☐ Thyroid Disease
☐ Glaucoma	☐ Heart Problems/Stroke	☐ Arthritis

Explain checks/OTHER:____

Does your vision limit any activities of daily living such as driving, reading, work, or sports? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO If yes, How Much?______________________________

Do you smoke? ☐ YES ☐ NO If yes, How Much?______________How long?______________

Physician Initials/Date: __________ __________ __________