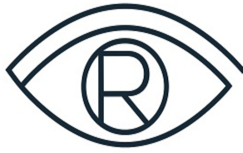

REED Eye Care Center

Many medical conditions and medications can affect your eyes and vision. Please answer questions as best as you can. This enables us to take care of you in the best and most efficient way.

Patient Name: ____ **Date of Birth:**_______________________
Address: ____
Last four of Social Security Number:______ **eMail:** ____
Phone Number:______________________________

Primary Care Physician: ____
PCP Phone Number:_______________________ **Date of last visit with PCP:** ____________________
Pharmacy:_______________________ **Pharmacy Location:**_____________________________________

<u>What is the reason for today's visit? (Please Circle all that apply)</u>

Blurred Vision	Eye Strain	Eye Pain	Sensitivity to lights
Headaches	Poor night vision	Night glare	Double vision
Loss of vision	Redness	Burning/Itching	Tearing/Watering
Discharge	Floaters	Flashes of light	Glasses/Contacts

<u>Patient Vision Needs</u>

Date of last Eye Exam (or approximate date)____
How old are your current glasses? ____
Do you wear contact lenses? If yes, which?____
How many hours per day do you use the computer? ____
What is your occupation? ____
Describe any unique visual demands at work or with hobbies?_____________________________________

<u>Have you ever been diagnosed with any of the following eye conditions? Circle all that apply:</u>

Cataract	Macular degeneration	Diabetic retinopathy
Dry eye	Lazy Eye	Floaters
Iritis or Uveitis	Retina detachment/degenerations	Glaucoma

<u>Have you ever had surgery on your eyes?</u> (Yes/No)

LASIK	Cataract	Surgery	Retinal Surgery	Laser	Injections

Other____

<u>Have you ever had injuries to your eyes?</u> (Yes/No) ____

(Over)

Patient Review of Health

Do you currently have problems in the following areas?

Please select Y/N and <u>Circle</u> the condition(s) or list if not shown	Y	N
Constitution (Fever, Weight Loss/Weight Gain)		
Cardiovascular/Vascular (High Blood Pressure, Stroke, Heart Disease)		
Ears, Nose, Throat, Mouth (Allergies, Sinus Congestion, Dryness)		
Respiratory (Asthma, Bronchitis, Emphysema, COPD)		
Gastrointestinal		
Genitourinary (Kidney, Bladder Problems)		
Musculoskeletal (Arthritis, Joint/Muscle Pain)		
Integumentary (Skin Problems, Eczema, Rash)		
Neurological (Headaches, Migraines, Seizures)		
Psychiatric (Anxiety/Depression/Bipolar)		
Endocrine (Diabetes, Thyroid/Other Gland Problem)		
Hematologic/Lymphatic (High Cholesterol, Anemia, Bleeding Problems)		
Immunologic/ **Autoimmune** (Rheumatoid, Sjogrens, Lupus)		

Do you take any medications, prescription and/or over the counter? Yes/No

____
____
____
____

Do you have any allergies to medications? ____
____

Are you currently Pregnant or Nursing? Yes / No

<u>Family history</u>: Please record the relative if any have been diagnosed with the following conditions:

Diabetes Yes/No ___________________________
Macular Degeneration Yes/No_______________
Retinal Disease Yes/No ______________________
Lazy Eye/Amblyopia Yes/No _________________

High Blood Pressure Yes/No __________________
Glaucoma Yes/No ____________________________
Eye Turn/Strabismus Yes/No __________________
Loss of Vision/ Blindness Yes/No ______________

<u>Patient Social History</u> (Please Circle the choice that applies to you)

Do you smoke tobacco?	Never	Socially	Daily	Former Smoker
Do you drink alcohol?	Never	Socially	Daily	Former Drinker
Do you use marijuana?	Never	Socially	Daily	________________

Is there any other information you would like the doctor to know?
____
____