Sunset Eye Clinic, LLC

1. PATIENT INFORMATION

Name:_____Age _____Date:_____

Occupation _____Employer_____Last Medical Exam _____

Medical Doctor's Name_____Dr's Phone Number_____

2. EYE HEALTH HISTORY (Please check any symptom / condition that applies)

□ Need new glasses / contact lens	□ Lazy Eyes	□ Flashes/floaters in vision	□ Itchy Eyes	□ Cataracts
□ Blurry Distance Vision	□ Double Vision	□ Temporary Vision Loss	□ Watery Eyes	□ Macular Degeneration
□ Blurry Near Vision	□ Loss of side Vision	□ Foreign Body sensation	□ Burning	□ Glaucoma
□ Tired Eyes	□ Headache	□ Dry Eyes	□ Infection	□ Eye Injury
□ Computer Eye Strain	□ Light Sensitivity	□ Redness	□ Sties	□ Other
			□ Lasik/Refractive Surgery	

Date of Last Eye Exam:_____Do you wear contact lenses (Y / N) Are you interested in contact lenses (Y / N)

Do you wear glasses (Y / N) Do you use a computer regularly (Y / N), if so, how many hours:_____

3. Review of Systems (Do you currently, or have you ever had any problems in the following areas, check all that apply)

Constitutional	**Ear, Nose, Throat, Mouth**	**Respiratory**	□ High Blood Pressure	**Bones/Joints/Muscles**
□ Fever	□ Allergies/Hay Fever	□ Asthma	□ Vascular Disease	□ Rheumatoid Arthritis
□ Weight Loss	□ Sinus Congestion	□ Chronic Bronchitis	**Gastrointestinal**	□ Muscle Pain
□ Weight Gain	□ Runny Nose	□ Emphysema	□ Diarrhea	□ Joint Pain
Endocrine	□ Post-Nasal Drip	**Vascular**	□ Constipation	**Lymphatic/Hematologic**
□ Thyroid/other glands	□ Chronic Cough	□ Diabetes	**Genitourinary**	□ Anemia
Psychiatric	□ Dry Throat/ Mouth	□ Heart Pain	□ Kidney/Bladder	□ Bleeding Problems
_____	**Allergic/Immunologic**	□ High Cholesterol	**Integumentary/Skin**	
	_____		_____	

If you answered YES to any of the above or have a condition not listed, please explain: _____

_____

List any medications you take including birth control, over the counter medications, eye drops, and home remedies:

_____

_____

Allergies to any medications:_____ Are you pregnant/Nursing (Y / N)

4. FAMILY HISTORY (Please check if your relatives had / have any of the following conditions)

□ Blindness □ Crossed Eyes □ Retinal Problems □ High Blood Pressure □ Cataract □ Glaucoma □ Arthritis

□ Macular Degeneration □ Diabetes □ Kidney Disease □ Cancer □ Thyroid Disease □ Lupus □ Other

5. Social History (This information is kept confidential. However, you may discuss this portion with the doctor.)

Do you drive? □ No □ Yes If yes, do you have visual difficulty when driving? □ No □ Yes

Do you use cigarettes/tobacco?_____Alcohol?_____Other Substances?_____

Have you ever been exposed to or infected with: □ Gonorrhea □ Hepatitis □ HIV □ Syphilis

Doctor's Signature_____