# SUNSET EYE CLINIC | SUNSET VISION CENTER, LLC

## PATIENT INFORMATION

Name:_____ Age _____Today's Date: _____

Occupation _____Employer _____Last Medical Exam_____

Primary Care Physician's Name_____ Dr's Phone Number_____

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

| | | | | |
|---|---|---|---|---|
| oNeed new glasses / contact lens | oLazy Eyes | oFlashes/floaters in vision | oItchy Eyes | oCataracts |
| oBlurry Distance Vision | oDouble Vision | oTemporary Vision Loss | oWatery Eyes | oDry Eyes |
| oBlurry Near Vision | oLoss of side Vision | oForeign Body sensation | oBurning | oSties |
| oGlaucoma | oTired Eyes | oHeadache | oMacular Degeneration | |
| o Infection | oEye Injury | oComputer Eye Strain | o Light Sensitivity | |
| o Redness | oLasik/Refractive Surgery | | oOther | |

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:_____

## REVIEW OF SYMPTOMS (Do you currently have any problems in the following areas, check all that apply)

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

If you 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 )

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

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

o Macular Degeneration o Diabetes o Kidney Disease o Cancer o Thyroid Disease o Lupus o Other_____

## SOCIAL HISTORY (This information is kept confidential. However, you may discuss this portion with the doctor.)

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

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

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

Doctor's Signature_____