FLORIDA EYE ASSOCIATES

DATE _____

PATIENT_____ **CHART #**_____

PHARMACY: _____ **Pharmacy Address:** _____

MEDICAL HISTORY OR PROBLEMS FOR WHICH YOU TAKE MEDICATION

(Circle all that apply or none)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial Joints	End Stage Renal Disease	Lymphoma
Asthma	GERD/Acid Reflux	Pacemaker
Atrial Fibrilation/Irregular Heartbeat	Hearing Loss	Prostate Cancer
BPH/Enlarged Prostate	Hepatitis	Radiation Treatment
Bone Marrow Transplant	Hypertension/High Blood Pressure	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	High Cholesterol	Valve Replacement
COPD/Chronic Obstructive Pulmonary Disease	Hyperthyroidism	NONE
Coronary Artery Disease	Hypothyroidism	

OTHER _____

PAST SURGICAL HISTORY (List any surgeries or circle none) NONE

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OCULAR HISTORY (Circle all that apply or none)

Allergic Conjunctivitis (Right, Left)	Glaucoma (Right, Left)	Pseudoexfoliation (Right, Left)
Blepharitis (Right, Left)	Macular Degeneration (Right, Left)	Posterior Vitreous Detachment (Right, Left)
Cataract (Right, Left)	Macular ERM (Right, Left)	Retinal Tears (Right, Left))
Corneal Dystrophy (Right, Left)	Narrow Angles (Right, Left)	Strabismus (Right, Left)
Diabetic Retinopathy (Right, Left)	Ocular Hypertension (Right, Left)	Vitreous Floaters (Right, Left)
Dry Eyes (Right, Left)	Ophthalmic Migraine (Right, Left)	Glasses, Contacts
OTHER _____		NONE

OCULAR SURGERY (Circle all that apply or none)

Lid Surgery (Right, Left)	Intravitreal Injection (Right, Left)	Glaucoma Laser Surgery (Right, Left)
Cataract Surgery (Right, Left)	LASIK/PRK (Right, Left)	YAG Laser / after cataract surgery (Right, Left)
Corneal Transplant/DSAEK (Right, Left)	Punctal Plugs (Right, Left)	
Eye Muscle Surgery (Right, Left)	Retinal Laser (Right, Left)	NONE
OTHER _____		

FAMILY HISTORY (Circle all that apply and list family member or circle none)

	MOTHER	FATHER	OTHER		MOTHER	FATHER	OTHER		MOTHER	FATHER	OTHER
Blindness				Glaucoma				Retinal Detachment			
Cancer				Heart Disease				Strabismus			
Cataracts				Macular Degeneration				Stroke			
Diabetes				Migraine				NONE			

OTHER _____

REFERRING DOCTOR: _____ **PRIMARY DOCTOR:** _____

MEDICATIONS (List any medications, or give technician your list or circle none) **NONE**

_____

_____

_____

ALLERGIES (List any allergies or circle no known allergies) **NO KNOWN ALLERGIES**

_____

_____

_____

SOCIAL HISTORY (Circle all that apply)

Cigarette Smoking:
- Never Smoked
- Quit/Former Smoker
- Smokes Less Than Daily
- Smokes Daily

Illegal/Street Drugs:
- Drug use/IV Drug use

Alcohol Use:
- None
- Less than 1 drink per day
- 1-2 Drinks per day
- 3 or more drinks per day

Circle any condition you are currently experiencing

EYES:	**SKIN:**
Sudden loss or change in vision	Rash
Burning or itching; excessive tearing	Excessive dryness
CONSTITUTIONAL:	**NEUROLOGICAL:**
Fever	Headache
Weight loss or weight gain	Loss of balance
EAR, NOSE & THROAT:	**MUSCULOSKELETAL:**
Sinus pressure/congestion	Arthritis
Hearing loss	Pain or swelling
HEART:	**HEMATOLOGIC/LYMPHATIC:**
Chest pain	Increased frequency of infections
Shortness of breath	Non-healing wounds
RESPIRATORY:	**ALLERGIC/IMMUNOLOGIC:**
Cough (sputum, blood)	Allergies to new medicines/foods/clothing
Wheezing	Hay fever
GASTROINTESTINAL:	**PSYCHIATRIC:**
Nausea/vomiting	Depression
Diarrhea	Anxiety
GENITOURINARY:	**ENDOCRINE:**
Incontinence	Increased urination or thirst
Blood in urine	Palpitations