

CAPITAL EYE CONSULTANTS, P.C.

YOUR NAME _____ BIRTH DATE _____

	Yes	No
Do you drive?	()	()
Do you have visual difficulty when driving?	()	()
Do you currently wear contact lenses?	()	()
If yes, for how long have you been a contact lens wearer?	_____	
Do you currently wear glasses?	()	()
Do you drink alcohol?	()	()
Do you smoke?	()	()
Have you ever had a blood transfusion?	()	()

Do you currently have any problems in the following areas?

	Yes	No		Yes	No
ALLERGIC AND IMMUNOLOGIC			Redness	()	()
Seasonal allergies	()	()	Itching	()	()
Hay fever symptoms	()	()	Burning	()	()
CARDIOVASCULAR (heart, blood vessels)			Foreign body sensation	()	()
High blood pressure	()	()	Eye pain or soreness	()	()
Heart problems	()	()	Other _____		
Elevated cholesterol	()	()	GASTROINTESTINAL (stomach, intestines, bowel problems)	()	()
RESPIRATORY (lungs, breathing)			GENITOURINARY (genitals, kidneys, bladder)		
Coughing	()	()	Kidney stones	()	()
Asthma	()	()	Bladder problems	()	()
ENDOCRINE			MUSCULOSKELETAL		
Thyroid problems	()	()	Joint pain, swelling, arthritis	()	()
Diabetes	()	()	HEMATOLOGICAL/LYMPHATICS		
EAR, NOSE, MOUTH, THROAT			Anemia	()	()
Sinus problems	()	()	Lymph nodes, swelling	()	()
Hearing problems	()	()	INTEGUMENT (skin, breasts)		
EYES			Rashes	()	()
Blurred vision	()	()	Skin ulcers	()	()
Loss of vision	()	()	NEUROLOGICAL		
Loss of side vision	()	()	Strokes	()	()
Double vision	()	()	PSYCHIATRIC	()	()
Glare/light sensitivity	()	()			
Dryness	()	()			
Sandy or gritty feeling	()	()			
Mucous discharge	()	()			
Excess tearing, watering	()	()			

History reviewed by: _____

History reviewed by: _____

List all current illnesses you have:

List your oral or injected medications:

List any eye surgeries or injuries you have had:

List any eye drops you take:

NON-PRESCRIPTION _____

PRESCRIPTION _____

Do you have allergies to any medications? YES () NO ()

Yes No

Yes No

FAMILY HISTORY

Blindness () ()
Cataract () ()
Glaucoma () ()
Macular degeneration () ()
Retinal detachment () ()
Arthritis () ()
Cancer () ()
Diabetes () ()

Heart attacks () ()
High blood pressure () ()
Kidney disease () ()
Immune system disorders () ()
Stroke () ()
Thyroid disease () ()
Other _____

History reviewed by: _____