Gadsden Eye Associates, P.C.

Patient Name_____Date_____
Gender_____Date of Birth_____Age_____
Previous Eye Doctor_____Medical Doctor_____

Ocular History
Have you ever had eye disease, surgery, or injury in the past? No___ Yes___
If yes, please list doctor and date of treatment.
Doctor_____ Date_____
Describe_____
Did any previous eye disorder result in loss of vision? No___ Yes___
If yes, please describe_____
Have you ever worn glasses or contact lens? No___ Yes___
How old is your current prescription?_____
Have you ever been told you have amblyopia or "lazy eye"? No___ Yes___

Medical & Surgical History
Have you ever had any serious medical problems? No___ Yes___
(For example: Heart, Lung, Kidney Disease, High Blood Pressure, Cancer or AIDS)
If yes, please describe_____
Do you have diabetes? No___ Yes___
How long have you had diabetes?_____
How often do you see your medical doctor for this condition?_____
How often do you test your blood sugar?_____urine sugar_____
What was your blood sugar when last tested?_____
Have you ever had an insulin reaction? No___ Yes___
Have you ever been hospitalized for any reason? No___ Yes___
If yes, please describe_____
Have you ever had any major surgery? No___ Yes___
If yes, please describe_____
Have you ever had any complications from anesthesia? No___ Yes___

Social History
Educational Level: High School No___ Yes___
College No___ Yes___
Post-graduate No___ Yes___
Do exercise 3 to 4 times a week? No___ Yes___
Drink Alcohol? No___ Yes___
Smoke? No___ Yes___
Live Alone? No___ Yes___
Present Occupation_____

Family History
Are there any eye diseases within your family? No___ Yes___
(For example: Glaucoma, Retinal or Macular Degeneration)
If yes, please describe_____
Have any member of your family lost vision for any reason? No___ Yes___
If yes, please describe_____
Are there any significant medical diseases that run in your family? No___ Yes___
(For example: Heart, Lung, Kidney Disease, High Blood Pressure or Cancer)
If yes, please describe_____

Review of Systems
Do you currently have any of the following?

Cardiovascular		**Pulmonary**	
Chest Pain	No___Yes___	Asthma/Emphysema	No___Yes___
Enlarged Heart	No___Yes___	Lung Disease	No___Yes___
Heart Disease	No___Yes___	Pneumonia	No___Yes___
Irregular Heart Beat	No___Yes___	T.B.	No___Yes___
Shortness of Breath	No___Yes___	Bronchitis	No___Yes___
Swelling of Feet	No___Yes___		
High Blood Pressure	No___Yes___		
Hematology		**Endocrine**	
Anemia	No___Yes___	Thyroid Disease	No___Yes___
Bleeding Disease	No___Yes___	Diabetes	No___Yes___
Hepatitis	No___Yes___	Sarcoidosis	No___Yes___
Sickle Cell Disease	No___Yes___		
Neurology		**Gastroenterology**	
Stroke	No___Yes___	Stomach Problems	No___Yes___
Seizures	No___Yes___	Intestinal Problems	No___Yes___
Paralysis	No___Yes___	Ulcer Disease	No___Yes___
Dizziness	No___Yes___		
Double Vision	No___Yes___		
Genitournary		**Rheumatology**	
Kidney Trouble	No___Yes___	Joint Problems	No___Yes___
Urinary Problems	No___Yes___	Back Problems	No___Yes___
		Plaquenil Use	No___Yes___
Psychiatry			
Depression	No___Yes___		
Other disorders	No___Yes___		

Do you have any drug allergies? No___Yes___
If yes, please list_____

Are you currently taking any medications, including eye drops? No___Yes___
If yes, please list_____
_____

_____Date_____
Signature of Patient or Responsible Party

Physician signature_____Date_____