

The Eye Center

Medical & Surgical Eye Care
Laura Muller, M.D.

Name _____ Date: _____

Occupation _____ Age: _____

How did you hear about our practice? _____

Referring Doctor _____ Primary Care Doctor _____

Reason for visit _____

Past Medical History: Please circle if you have any of the following conditions:

Diabetes (sugar) **High Blood Pressure** **Heart disease** **HIV** **Cancer** type: _____

Other (Please list) _____

Medications (For eye drops please list on back page)

<u>Name</u>	<u>Dosage</u>	<u># times a day</u>	<u>Name</u>	<u>Dosage</u>	<u># times a day</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Previous Surgery (please list):

Drug Allergies (please list) _____

Family History: Do any of the following conditions run in the family? (Please circle and list who)

Diabetes _____ Blindness _____ Glaucoma _____

Cancer _____ Other conditions: _____

Smoking/Tobacco: Yes / No _____ # packs per day Age when started? _____ Age when quit _____

Alcohol: Yes / No _____ drinks per day / month / year

Recreational Drug Use: Yes / No List type(s): _____

Review of Systems: Do you have any of the following symptoms? **Circle Yes / No**

Fevers	Yes / No	Rashes	Yes / No
Fatigue	Yes / No	Urinary Frequency	Yes / No
Night Sweats	Yes / No	Increased thirst or appetite	Yes / No
Headaches	Yes / No	Heat or cold intolerance	Yes / No
Hearing loss	Yes / No	Dizziness	Yes / No
Cough	Yes / No	Emotional distress	Yes / No
Chest Pain	Yes / No	Joint pain	Yes / No
Vomiting	Yes / No	Weakness	Yes / No
Diarrhea	Yes / No	Difficulty walking	Yes / No
Constipation	Yes / No	Easy bruising	Yes / No
Painful urination	Yes / No	Abnormal bleeding	Yes/No
Blood in urine	Yes / No	Food or environmental allergies	Yes/No

Past Ocular History:

Date of your last eye exam? _____

Who performed your last eye exam? _____

Do you wear glasses? **Yes / No** Contact lenses? **Yes / No** Reading glasses? **Yes / No**

Contact lens wearers:

What Brand do you wear?: _____

What is the power/BC and Dia (if known)?: _____

How often do you replace the lenses? _____

How many hours a day do you wear your lenses? _____

Do you sleep in your contact lenses? _____

Would you like to decrease your dependence on glasses or contact lenses? **Yes / No**

Please circle or list any eye diseases you have:

Glaucoma, Cataract, Dry eye, Retinal detachment, Diabetic retinopathy

Other eye conditions: _____

Do you use eye drops? Yes / No

Prescription eye drops: _____

Artificial tears: _____

For prescriptions we might write for you, do you have a pharmacy that you prefer to use?

Pharmacy Name: _____ Corner of: _____

Address: _____ City: _____ State: _____

Phone #: () _____ - _____ Fax #: () _____ - _____

Have you had any **eye surgery**? Please list with dates and surgeon:

Do you have any of the following? (**Circle Yes or No**) (**If Yes, circle right, left eye or both**)

Blurred vision	Yes / No	If Yes, circle Right, Left or Both eyes
Double vision	Yes / No	If Yes, circle Right, Left or Both eyes
Scratchy sensation	Yes / No	If Yes, circle Right, Left or Both eyes
Dry sensation	Yes / No	If Yes, circle Right Left or Both eyes
Tearing	Yes / No	If Yes, circle Right, Left or Both eyes
Discharge	Yes / No	If Yes, circle Right, Left or Both eyes
Pain in eyes	Yes / No	If Yes, circle Right, Left or Both eyes
Flashing Lights	Yes / No	If Yes, circle Right, Left or Both eyes
Floaters	Yes / No	If Yes, circle Right, Left or Both eyes
Distortion of vision	Yes / No	If Yes, circle Right, Left or Both eyes
Difficulty with vision using a computer?	Yes / No	If Yes, circle Right, Left or Both eyes