LEGARRETA EYE CENTER

Thank you for choosing our practice. To better serve you, please fill out the information below to the best of your ability.

____________	____________	____________	____________
Date (mm/dd/yy)	Primary Doctor	referred by	birthdate

______________________________ Patient's name ________ sex ______ age

______________________________ Email address

Family & Social History

Do any medical or eye diseases run in your family? (e.g., diabetes, high blood pressure, cancer, glaucoma, macular degeneration) yes no If YES, explain: ____

____

Do you drink alcohol? yes no If YES: occasional 1/day 2-3/day 4-+/day

Do you smoke? yes no If YES: occasional 1/2 pack/day 1 pack/day 1+pack/day

Current occupation:_______________ Marital status: widowed married single divorced

Please answer the following questions about your medical status & history:

1. Have you ever been treated for any medical conditions (e.g, diabetes, high blood pressure, arthritis, etc)
   Arthritis……………………….……………Yes No How long? ____________________
   Migraine headaches………………………... Yes No How long? ____________________
   Diabetes…………………………………… …Yes No How long? ____________________
   High Blood Pressure…………………………..Yes No How long? ____________________
   Thyroid Problems……………………………..Yes No How long? ____________________
   Heart Disease………………………………….Yes No How long? ____________________
   Other…………………………………….…….Yes No How long? ____________________
2. Have you ever had any eye disease (e.g, glaucoma, cataract, wandering or "lazy"eye, retinal detachment,dry eye)?
   Yes No If YES, explain:____
3. Have you ever had any surgery: Yes No If YES, explain: ____________________
   ____
4. Have you ever been hospitalized? Yes No If YES, explain: ____________________
   ____
5. Do you take any medications? Yes No
   If YES, list: _________ ______________ ______________ ______________
   ______________ ______________ ______________ ______________
   ______________ ______________ ______________ ______________
   ______________ ______________ ______________ ______________

Do you take any eye medications? Yes No If YES, please list: ____________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Do you have any drug or food allergies? Yes No If YES, please list____________ ______________

______________ ______________ ______________ ______________

______________ ______________ ______________ ______________

Do you currently have any of the following problems?

Chronic fever, unexpected weight gain/lose, fatigue ………………………….. Yes No____________________
Ear/nose/mouth/throat problems (e.g., hearing loss, sinus problems, sore throat)... Yes No ____________________
Heart problems (e.g., chest pain, irregular heart beat) ……………………........ Yes No ____________________
Respiratory problems (e.g., shortness of breath, wheezing, coughing)…………… Yes No ____________________
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, vomiting).... Yes No ____________________
Urinary problems (e.g., pain or discomfort, blood in urine)……………………... Yes No ____________________
Skin problems (e.g., rashes, excessive dryness) ………………………………… Yes No ____________________
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints)……… Yes No ____________________
Neurological problems (e.g., numbness, weakness, headaches, paralysis)……… Yes No ____________________
Psychiatric problems (e.g., depression, anxiety)………………………………… Yes No ____________________
Endocrine……………………………………………………………………… Yes No ____________________
Hematologic/Lymphatic ……………………………………………………… Yes No ____________________
Allergic/Immunologic ……………………………………………………….... Yes No ____________________
All others negative ………………………………………………………….... Yes No ____________________

EYES	YES	NO	EYES	YES	NO
Loss of vision			Sandy		
Blurred vision			Itching		
Distorted vision (halos)			Burning		
Glare or light sensitivity			Foreign body sensation		
Loss of side vision			Excess tearing or watering		
Double vision			Dryness		
Crossed eyes, lazy eye			Mucous discharge		
Infection of eye or lid			Redness		
Drooping eyelid			Tired eyes		
Soreness			Ache		
Ocular fatigue			Discomfort (irritation)		
Sticky Tears			Grittiness		
Eye pain			Swollen, red eyelids		
Scratchiness			Blurry (fluctuating) vision		
Light sensitivity			Stinging		

______________________________________ ________ ________ ________ ________
Signature of patient (or guardian, if minor) Date Pt int/date PT int/date PT int/date

______________________________________ ________ ________ ________ ________
Physician’s signature Date Pt int/date PT int/date PT int/date _