SEWICKLEY EYE GROUP

NAME: _____DOB: _____ TODAY'S DATE: _____

CURRENT VISUAL COMPLAINTS - Do you have?

	Yes	No
Blurred vision for reading/distance	_____	_____
Glare problems due to sunlight	_____	_____
Glare problems while driving at night	_____	_____
Double Vision	_____	_____
Floaters	_____	_____
Pain	_____	_____

PAST EYE HISTORY – Have you been told you have?

	Yes	No
Cataracts	_____	_____
Glaucoma	_____	_____
Crossed Eyes or Lazy Eye	_____	_____
Macular Degeneration	_____	_____
Retina Disorders	_____	_____
Corneal Disorders	_____	_____

PREVIOUS EYE SURGERIES OR LASER EYE TREATMENTS (list type of surgery, which eye, date of surgery, and surgeon's name):

_____

LIST ANY OTHER SIGNIFICANT PAST EYE PROBLEMS (double vision, eye injuries, etc.):

_____

OTHER PAST MEDICAL HISTORY (Do you have or been treated for?)

	Yes	No
Diabetes. Year Diagnosed?	_____	_____
Heart Attack Year?_____	_____	_____
Stroke Year? _____	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
Hepatitis A, B or C	_____	_____
Tuberculosis	_____	_____

	Yes	No
Aids	_____	_____
Cancer: Type?_____	_____	_____
Thyroid Disease: Hypo or Hyper	_____	_____
Crohn's Disease/Ulcerative Colitis	_____	_____
Asthma/Emphysema/Chronic Bronchitis	_____	_____
Auto Immune Disease. Type?_____	_____	_____
Other _____	_____	_____

OTHER SURGICAL HISTORY (list all surgeries (non-eye related that you have had):

_____

REVIEW OF SYSTEMS (circle condition(s) that apply):

Constitutional: fever, weight loss, weight gain, fatigue
ENT: deafness, hard of hearing, sinus trouble
Cardiovascular: heart failure, chest pain, pacemaker
Gastrointestinal: diarrhea, constipation
Psychiatric: depression, anxiety
Neurologic: dizziness, weakness, seizures
Musculoskeletal: arthritis, back pain
Hematologic: bleeding problems, anemia
Respiratory: shortness of breath, COPD
Skin: rashes, eczema, psoriasis

SOCIAL HISTORY (circle one in each category):

Cigarettes: Never smoked / Former smoker / Current Smoker ____# packs per day / Tobacco chewer / Pipe smoker
Alcohol: Non-drinker / Light / Moderate / Heavy / Social
Recreational Drugs: Non-drug user / Drug user

FAMILY EYE & MEDICAL HISTORY (Circle all that apply, blood relatives *only*)

Glaucoma Cataracts Diabetes Macular Degeneration Lazy Eye Heart Disease Blindness Retinal Detachment

MEDICATIONS (include strength and how many times a day you take each):

EYE MEDICATIONS	ORAL MEDICATIONS	HERBS, SUPPLEMENTS & VITAMINS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____