

THE SEWICKLEY EYE GROUP

SEWICKLEY OFFICE
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(724) 770-9000

AVALON OFFICE
(412) 766-4800

NAME: _____ DOB: _____ TODAY'S DATE: _____

CURRENT VISUAL COMPLAINTS - Do you have:

EYE HISTORY – Have you been told you have:

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

	Yes	No
Cataract	_____	_____
Glaucoma	_____	_____
Crossed Eyes or Lazy Eye	_____	_____
Macular Degeneration	_____	_____

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.): _____

FAMILY EYE & MEDICAL HISTORY (is there a family history, **blood relatives only**, and list relation):

Glaucoma _____	Fhx of Diabetes Mellitus _____
Cataract _____	Fhx of Cancer _____
Macular Degeneration _____	Fhx of Cardiovascular Disease _____
Retinal Disorder _____	Fhx High Cholesterol _____
Blindness/Vision Impairment _____	Fhx Hypertension _____
Strabismus (cross eyed) _____	Fhx Kidney Disease _____
Amblyopia (lazy eyed) _____	Fhx Stroke _____

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

EYE MEDICATIONS

ORAL MEDICATIONS

HERBS, SUPPLEMENTS & VITAMINS

PAST MEDICAL HISTORY (circle condition(s) that apply):

High blood pressure	Crohn's disease/Ulcerative colitis	Lupus	Stroke ____ year
High cholesterol	Autoimmune disease	Thyroid disease*	TB
Hepatitis A / B / C	Diabetes* ____ year diagnosed	*hypo or hyper	AIDS
Asthma/Emphysema/Chronic Bronchitis	*insulin or non-insulin	Heart attack ____ year	Cancer ____ type
Other			

SURGICAL HISTORY (list all surgeries 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
Skin: rashes, eczema, psoriasis

Neurologic: dizziness, weakness, seizures
Musculoskeletal: arthritis, back pain
Hematologic: bleeding problems, anemia
Respiratory: shortness of breath, COPD
Other:

SOCIAL HISTORY (circle one):

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

Hobbies: _____ **Special Visual needs:**

PCP NAME: _____ OPTOMETRIST NAME: _____ Height: ____ Weight: ____