# THE SEWICKLEY EYE GROUP

| SEWICKLEY OFFICE | OHIO VALLEY OFFICE | BEAVER VALLEY OFFICE | AVALON OFFICE |
|---|---|---|---|
| (412) 741-4610 | (412) 777-4300 | (724) 770-9000 | (412) 766-4800 |

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 | _____ | _____ |

Other: _____

**EYE HISTORY** – Have you been told you have:

| | 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 _____
Cataract _____
Macular Degeneration _____
Retinal Disorder _____
Blindness/Vision Impairment _____
Strabismus (cross eyed) _____
Amblyopia (lazy eyed) _____

Fhx of Diabetes Mellitus _____
Fhx of Cancer _____
Fhx of Cardiovascular Disease _____
Fhx High Cholesterol _____
Fhx Hypertension _____
Fhx Kidney Disease _____
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:** ____