THE SEWICKLEY EYE GROUP

SEWICKLEY EYE CENTER	OHIO VALLEY EYE CENTER	BEAVER VALLEY EYE CENTER	ALLEGHENY EYE CENTER
(412) 741-4610	(412) 777-4300	(724) 770-9000	(412) 766-4800

NAME: _____ **DOB:** _____ **DATE:** _____

CURRENT VISUAL COMPLAINTS - Do you have:

	Yes	No
Blurred vision for reading	____	____
Blurred vision for distance	____	____
Clare problems due to sunlight	____	____
Glare problems while driving at night	____	____
Other: _____		

PAST EYE HISTORY - Have you been told to have:

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

PREVIOUS EYE SURGERIES, INCLUDING LASERS: List 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 of (circle conditions that apply and list relation in space provided):

Glaucoma _____ Macular Degeneration _____
Cataract _____ Crossed or Lazy Eye _____
Diabetes _____ Heart Disease _____

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

EYE MEDICATIONS	ORAL MEDICATIONS	HERBS & SUPPLEMENTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ALLERGIES & <u>REACTIONS</u> TO MEDICINE, SEASONAL OR ENVIRONMENTAL CONDITIONS: _____

_____

_____

PAST MEDICAL HISTORY (circle conditions that apply):

High blood pressure	Asthma/Emphysema/Chronic bronchitis	Lupus	Diabetes	Cancer
High cholesterol	Crohn's disease/Ulcerative colitis	Thyroid disease*	Heart attack	TB
Hepatitis	Autoimmune disease	* hypo or hyper	Stroke	AIDS

Other _____

_____

_____

_____

REVIEW OF SYSTEMS (**check** any categories that apply **and circle** any conditions 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
___ Other: _____
_____

SOCIAL HISTORY: Cigarette Smoking: NO YES - number of packs per day ____
Alcohol: Circle appropriate response: Never Rarely Occasionally Frequently
Hobbies/Visual needs: _____

For office use only:

Date updated:	_____	_____	_____	_____	_____	_____	_____	_____
TECH:	_____	_____	_____	_____	_____	_____	_____	_____
MD/OD:	_____	_____	_____	_____	_____	_____	_____	_____