**Sharper Eyecare**

**General History**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_A**ge:**\_\_\_\_\_\_\_\_\_ **Sex**: Male / Female

**1. Allergies:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. History of the following diseases**: *(please place a check mark if* ***‘Yes’****)*

Self / Family Self / Family

**Respiratory** **Eye Diseases**

1. Asthma \_\_\_\_\_ / \_\_\_\_\_ 1. Cataracts \_\_\_\_\_ / \_\_\_\_\_

2. Bronchitis \_\_\_\_\_ / \_\_\_\_\_ 2. Glaucoma \_\_\_\_\_ / \_\_\_\_\_

3. Emphysema \_\_\_\_\_ / \_\_\_\_\_ 3. Macular degeneration \_\_\_\_\_ / \_\_\_\_\_

4. Oxygen dependent \_\_\_\_\_ / \_\_\_\_\_ 4. Retinal detachment \_\_\_\_\_ / \_\_\_\_\_

**Cardiac** **Kidney**

1. Heart Disease \_\_\_\_\_ / \_\_\_\_\_ 1. Renal insufficiency/failure \_\_\_\_\_ / \_\_\_\_\_

2. High Blood Pressure \_\_\_\_\_ / \_\_\_\_\_ 2. Dialysis dependence \_\_\_\_\_ / \_\_\_\_\_

3. Chest Pain \_\_\_\_\_ / \_\_\_\_\_ **Other disorders**

4. High cholesterol \_\_\_\_\_ / \_\_\_\_\_ 1. Hepatitis (Type: \_\_\_\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_

**Neurological** 2. Diabetes (Type: \_\_\_\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_

1. Stroke \_\_\_\_\_ / \_\_\_\_\_ 3. Cancer (Type:\_\_\_\_\_\_\_\_\_) \_\_\_\_\_ / \_\_\_\_\_

2. Seizure disorder \_\_\_\_\_ / \_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gastrointestinal** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Gastro-esophageal reflux \_\_\_\_\_ / \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Hiatal hernia \_\_\_\_\_ / \_\_\_\_\_

**3. Previous surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Tobacco use:** Yes / No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Quantity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you quit, how long ago? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Alcohol consumption?** Yes / No Quantity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Drug Abuse?** Yes / No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Current Medications:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. If you are female, possibility of pregnancy?** Yes / No

**9. Do you suffer from any of the following**:

Blurry vision \_\_\_\_\_\_\_\_\_ Sinus problems \_\_\_\_\_\_\_\_\_ Flashes of light \_\_\_\_\_\_\_\_\_

Dry eyes \_\_\_\_\_\_\_\_\_ Headaches \_\_\_\_\_\_\_\_\_ Halos \_\_\_\_\_\_\_\_\_

Watery eyes \_\_\_\_\_\_\_\_\_ Pain in your eyes \_\_\_\_\_\_\_\_\_ Floaters \_\_\_\_\_\_\_\_\_

Seasonal allergies \_\_\_\_\_\_\_\_\_ Dizziness \_\_\_\_\_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_

**10. Do you wear glasses or contact lenses?**  Yes / No 🡪 If yes to contacts: Soft Hard

**11. Approximate date of last eye exam**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present Eye Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Approximate date of last physical exam**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Present Medical Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Purpose of today’s visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**