**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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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:**

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

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**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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**