SOUTHSIDE EYE CARE
PROFESSIONAL EYE CARE & SURGERY

Revised 3/20/2018

Name_____**Date**_____

Reason for today's visit:_____

Pharmacy:_____ Location:_____Phone:_____

Severity of your symptoms: ☐Mild ☐Moderate ☐Severe

How long has this been a problem for you? _____

When does this bother you? ☐driving ☐reading ☐sleeping ☐all the time

Other_____

Is there anything that makes it better or worse?_____

Are you allergic to any medications?_____

List of current medications including eye drops:

_____ _____

_____ _____

_____ _____

_____ _____

Are your currently experiencing?

General	☐chills	☐fever	☐headache
Skin	☐rashes	☐lesions	☐shortness of breath
Ear/Nose/Throat	☐sinusitis	☐sore throat	
Cardiovascular	☐chest pain	☐palpitations	
Respiratory	☐wheezing	☐cough	
Gastrointestinal	☐nausea	☐vomiting	☐abdominal pain
Genitourinary	☐blood in urine		
Musculoskeletal	☐muscle pain	☐joint pain	☐weakness
Neurological	☐loss of balance	☐numbness	☐tingling
Psychiatric	☐depression	☐anxiety	
Endocrine	☐weight gain	☐weight loss	☐excessive thirst
Hematology	☐easy bruising	☐bleeding	
Immunologic	☐seasonal allergies		

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Eye History: Date of last eye exam:_____/_____/_____

Do you wear glasses or contacts for: ☐ reading ☐ distance vision ☐ computer use only ☐ daily

If not, have you had corrective vision surgery? ☐yes ☐no

Eye Symptoms: ***(Please mark all that apply)***

☐ Blurred Vision	☐ Flashing lights	☐ Light Sensitivity
☐ Discharge	☐ Floaters	☐ Pain
☐ Distortion of Vision	☐ Foreign Body Sensation	☐ Redness
☐ Double Vision	☐ Glare	☐ Tearing
☐ Dryness	☐ Itching	☐ Vision Loss

Ocular History: ***(Please mark all that apply)***

☐ Astigmatism	☐ Dry Eyes	☐ Iritis	☐ Macular Degeneration
☐ Cataracts	☐ Glaucoma	☐ Keratoconus	☐ Thyroid Eye Disease
☐ Diabetic Retinopathy	☐ Herpetic Eye Disease	☐ Lazy Eye or history of eye patch	

Have you ever had eye surgery? ☐ Yes ☐ No

If yes: Procedure_____ Date:_____

Procedure_____ Date:_____

Medical History: ***(Please Mark all that apply)***

☐ Alzheimer's Disease	☐ COPD	☐ HIV	☐ Parkinson's Disease	☐ Sleep Apnea
☐ Anemia/Blood Disorder	☐ Emphysema	☐ Irregular Heartbeat	☐ Rheumatoid Arthritis	☐ Stroke
☐ Asthma	☐ Heart Disease	☐ Lupus	☐ Rosacea/Eczema	☐ Syphilis
☐ Cancer	☐ Hepatitis	☐ Migraines	☐ Sarcoidosis	☐ TB
☐ Carotid Artery Disease	☐ High Cholesterol	☐ Multiple Sclerosis	☐ Sjogren's	

Other/Autoimmune Disease:_____

Are you diabetic? ☐ Yes ☐ No

If yes, since_____ ☐ Diet Controlled ☐ Medication ☐ Insulin ☐ Poorly controlled

Name of provider following diabetes:_____

Do you have hypertension? ☐ Yes ☐ No

If yes, since_____ ☐ Diet Controlled ☐ Medication ☐ Poorly controlled

List Any Previous Surgeries: *(Procedure/Year)*

_____

_____

_____

Family History: ***Please indicate on line whether this pertains to mother (M), father (F), siblings (S) and/or grandparents (G):***

☐ Auto Immune Disease	_____	☐ Glaucoma	_____	☐ Retinal Detachment	_____
☐ Cataracts	_____	☐ Heart Disease	_____	☐ Retinal Disorder	_____
☐ Cancer	_____	☐ Hypertension	_____	☐ Strabismus	_____
☐ Diabetes	_____	☐ Macular Degeneration	_____	Other: _____	

Do you smoke? ☐ Yes ☐ No If yes, how many packs a day? _____ How many years?_____

Do you drive? ☐ Yes ☐ No ☐ Daytime ONLY ☐ Locally ☐ with/without glasses

Are you pregnant or nursing? ☐ Yes ☐ No

Patient/Guarantor Signature_____**Date**_____