

# Digby Eye Associates

NAME \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Medical Doctor/Primary Care Physician \_\_\_\_\_

## PAST MEDICAL HISTORY

Please list any previous surgeries, injuries, or hospitalizations

Have you had any eye surgery or any eye injuries in the past? YES NO If yes, please list:

RIGHT EYE \_\_\_\_\_

LEFT EYE \_\_\_\_\_

SEX M / F \_\_\_\_\_ RACE \_C\_ \_AA\_ \_AI\_ \_A\_ \_O\_ \_\_\_\_\_ EYE COLOR \_Blu\_ \_Grn\_ \_Haz\_ \_Brn\_ \_\_\_\_\_

## REVIEW OF SYSTEMS

Please answer *all* of the following sections. Do you, or have you ever had any of the following conditions, diseases, or symptoms. Please check Yes or No.

<b>Cardiovascular</b>	yes no	<b>Ear/Nose/Throat</b>	yes no
High Blood Pressure	_____	Hearing loss	_____
Heart disease	_____	Wear hearing aids	_____
Heart attack	_____	Sinus problems	_____
Date: _____		<b>Genitourinary</b>	yes no
Angina	_____	Kidney problems	_____
Stroke	_____	Bladder problems	_____
Date: _____		Prostate problems	_____
<b>Endocrine</b>	yes no	<b>Hematological</b>	yes no
Diabetes	_____	Anemia	_____
Thyroid	_____	Bleed/bruise easily	_____
<b>Respiratory</b>	yes no	<b>Musculoskeletal</b>	yes no
Productive cough	_____	Osteoporosis	_____
Tuberculosis	_____	Joint replacement	_____
<b>Skin</b>	yes no	<b>Gastrointestinal</b>	yes no
Rashes	_____	Colitis	_____
Dermatitis	_____	Diverticulitis	_____
<b>Neurological</b>	yes no	Ulcers	_____
Seizures	_____	Liver/Hepatitis	_____
Paralysis	_____	<b>Psychiatric</b>	yes no
Alzheimer's	_____	Depression	_____
<b>Allergic/Immunologic</b>	yes no	Anxiety	_____
Environmental allergies	_____	Claustrophobia	_____
HIV/AIDS	_____	<b>Eyes</b>	yes no
<b>Constitutional</b>	yes no	Decreased vision	_____
Fever	_____	Double vision	_____
Weight loss	_____	Floaters	_____
Fatigue	_____		

If you answered YES to any of the above, please explain. \_\_\_\_\_

## FAMILY HISTORY

Does any person in your immediate family have any of the following conditions?

Diabetes	Y N	High Blood Pressure	Y N	Cataracts	Y N
Glaucoma	Y N	Retinal Detachments	Y N	Macular Degeneration	Y N
Strabismus	Y N	Other eye diseases	Y N, list _____		

## SOCIAL HISTORY

Do any of the following pertain to you? If yes, circle all that apply.

Smoke \_\_\_\_\_ Drink Alcohol \_\_\_\_\_ Use Recreational Drugs \_\_\_\_\_ Live Alone \_\_\_\_\_

PLEASE FILL OUT THE BACK OF THIS SHEET

## Lifestyle Questionnaire

Does your job include working on the computer? Yes \_\_\_\_\_ No \_\_\_\_\_

Are there any special vision requirements at work? Yes \_\_\_\_\_ No \_\_\_\_\_

What activities and sports do you engage in? (i.e., reading, fishing, sewing) Please list: \_\_\_\_\_

Are you satisfied with your distant, intermediate, and/or reading vision? Yes \_\_\_\_\_ No \_\_\_\_\_

If no, why? \_\_\_\_\_

Do you wear sunglasses? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have any problems with glare? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list ALL MEDICATIONS you are currently taking, including Aspirin.

I am not taking any medications at this time. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name \_\_\_\_\_ Strength \_\_\_\_\_ How often \_\_\_\_\_ Name \_\_\_\_\_ Strength \_\_\_\_\_ How often \_\_\_\_\_

Are you ALLERGIC to any medications? YES NO If yes, please list: \_\_\_\_\_

\*Doctor Use Only Below This Line\*

Physician Signature \_\_\_\_\_

## UPDATES

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ No Changes \_\_\_\_\_ Updates \_\_\_\_\_

Reviewed by \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ No Changes \_\_\_\_\_ Updates \_\_\_\_\_

Reviewed by \_\_\_\_\_

Date \_\_\_\_/\_\_\_\_/\_\_\_\_ No Changes \_\_\_\_\_ Updates \_\_\_\_\_

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Date \_\_\_\_/\_\_\_\_/\_\_\_\_ No Changes \_\_\_\_\_ Updates \_\_\_\_\_

Reviewed by \_\_\_\_\_