

Precision Eye Care, Inc.

Medical History

Name _____ Date : _____
 Email Address: _____ Emergency Contact _____
 Primary Care Physician _____ Pharmacy _____
 Date of Birth _____ Date of Last Eye Exam _____
 Ethnicity: Hispanic _____ Non Hispanic _____ Preferred Language: English / Other: _____ Race: _____

Eye Symptoms

	YES	NO		YES	NO		YES	NO		YES	NO
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	Burning	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Tearing	<input type="checkbox"/>	<input type="checkbox"/>	Pain	<input type="checkbox"/>	<input type="checkbox"/>	Floaters or Spots	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Glare or Halos	<input type="checkbox"/>	<input type="checkbox"/>
Other _____											

Review of Systems - Please answers YES or NO for each question

	YES	NO		YES	NO		YES	NO		YES	NO
Fever	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Rash	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Bruising	<input type="checkbox"/>	<input type="checkbox"/>
Increased Urination	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Increased Thirst	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Joint Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>

Please List medications you are currently taking (including eye medications)

Medication Name	Dosage	Medication Name	Dosage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to any medications? YES _____ NO _____ If YES _____

Ocular History

	YES	NO		YES	NO		YES	NO		YES	NO
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Injury	<input type="checkbox"/>	<input type="checkbox"/>	Crossed/Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Laser Treatments	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery or Other Procedure _____											

Medical History

	YES	NO		YES	NO		YES	NO		YES	NO
Diabetic _____ yrs.	<input type="checkbox"/>	<input type="checkbox"/>	ENT/ Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease/Stroke	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Immune Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Surgery/Other Procedures _____											

Family History

Cataracts	<input type="checkbox"/>	Macular Degeneration	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Other _____					

Social History

Do you smoke? YES _____ NO _____ Packs a Day/ Years _____ Former Smoker? YES _____ NO _____
 Have you had a pneumonia vaccination within the past year? YES _____ NO _____ Hobbies: _____