PATIENT NAME: _____ ID#: _____ DATE: _____

PAST EYE HISTORY

Contact lens wear: Yes / No How long_____ Age of present contacts _____ Daily wearing time _____

Glasses wear: Yes / No How long_____ Age of present glasses _____

Previous eye injury or infection: _____

Previous eye surgeries (include lasers) : _____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR MEDICAL STATUS AND HISTORY:

1. Have you ever been treated for any medical conditions? (e.g. diabetes, high blood pressure, arthritis, etc.)
   YES ☐ NO ☐ If YES, please explain: _____
2. Have you every had any eye disease? (e.g. glaucoma, cataract, wandering or "lazy" eye, retinal detachment)
   YES ☐ NO ☐ If YES, please explain: _____
3. Have you ever had any surgery?
   YES ☐ NO ☐ If YES, please provide date and reason: _____
   _____
4. Have you every been hospitalized?
   YES ☐ NO ☐ If YES, please provide date and reason: _____
   _____
5. Do you take any medications?
   YES ☐ NO ☐ If YES, please list: _____
   Do you take any eye medications?
   YES ☐ NO ☐ If YES, please list: _____
6. Do you have any drug or food allergies?
   YES ☐ NO ☐ If YES, please list: _____
   _____

REVIEW OF SYSTEMS	**YES**	**NO**	**If YES, please explain:**
Do you curently have any of the following problems:			
Chronic fever, unexpected weight loss/gain, fatigue	☐	☐	_____
Ear/nose/throat problems (e.g. hearing loss, sinus problems, sore throat)	☐	☐	_____
Heart problems (e.g. chest pain, irregular heart beat)	☐	☐	_____
Respiratory problems (e.g. shortnes of breath, wheezing, coughing)	☐	☐	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting)	☐	☐	_____
Urinary problems (e.g. pain or discomfort, blood in urine)	☐	☐	_____
Skin problems (e.g. rashes, excessive dryness)	☐	☐	_____
Musculoskeleton problems (e.g. muscle aches, joint pain, swollen joints)	☐	☐	_____
Neurologic problems (e.g. numbness, weakness, headaches, paralysis)	☐	☐	_____
Psychiatric problems (e.g. depression, anxiety)	☐	☐	_____

FAMILY AND SOCIAL HISTORY

Do any medical or eye diseases run in your family? (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration)
YES ☐ NO ☐ If YES, please list: _____

_____

ADULTS: Do you smoke? NO ☐ YES ☐ ....how much?_____ Drink alcohol? NO ☐ YES ☐ ....how much?_____

Are you employed? NO ☐ YES ☐ how many hours per week? _____ Occupation? _____

CHILDREN/ADOLESCENTS: Is this child a student? NO ☐ YES ☐ ....what grade? _____

Extracurricular activities: _____

COMMENTS: _____

_____

_____

_____

_____ _____

PHYSICIAN SIGNATURE: DANIEL KOZLOW, M.D. **DATE**

REV.3/14