SYRACUSE EYE CENTER

Name: ______________________________ Today's Date: ____________________

Birth Date: _______/_______/_______ Last Eye Exam: ____________________
Month Day Year

Reason for your visit today: ______________________________ Last Eye Doctor: ____________________

______________________________ Last Medical Exam: ____________________

______________________________ Current Medical Dr.: ____________________

Medical History

Do you have an allergy to any medication: Yes ☐ No ☐ If yes, please explain: ______________________________

____

List any medications you are taking (including oral contraceptives, aspirin, home remedies and over the counter medications):

__________ __________ __________ __________ __________

__________ __________ __________ __________ __________

List all physicians/specialists you are seeing: __________ __________ __________

__________ __________ __________ __________ __________

List all major injuries, surgeries and/or hospitalizations you have had:

Procedure	Date	Procedure	Date	Procedure	Date

Are you pregnant and/or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ____________________

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses? ____________________

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other Are they comfortable? ☐ Yes ☐ No

Have you had refractive surgery? ☐ Yes ☐ No What do you use your glasses for? ____________________

Family History

Have any of your relatives (living or deceased) had any of the conditions listed below?

Ocular Disease/Condition	Yes	No	Not Sure	Relationship To You
Blindness	☐	☐	☐	
Cataract	☐	☐	☐	
Crossed Eyes	☐	☐	☐	
Glaucoma	☐	☐	☐	
Macular Degeneration	☐	☐	☐	
Retinal Detachment/Disease	☐	☐	☐	
Systemic Disease/Condition				
Arthritis	☐	☐	☐	
Cancer	☐	☐	☐	
Diabetes	☐	☐	☐	
Heart Disease	☐	☐	☐	
High Blood Pressure	☐	☐	☐	
Kidney Disease	☐	☐	☐	
Thyroid Disease	☐	☐	☐	
Other __________	☐	☐	☐	

• ***Please turn this form over and complete side two*** ➡

Social History

This information is kept strictly confidential.

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No If yes, please describe:

____

Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/how long: ____________________

Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/how long: ____________________

Do you use illegal drugs? ☐ Yes ☐ No If yes, type/amount/how long: ____________________

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

Have you had a pneumonia vaccine in the past? ☐ Yes ☐ No

Review of Systems

Do you currently or have you ever had any problems in the following areas?

System	Yes	No	Not Sure
Eyes			
Cataract	☐	☐	☐
Glaucoma	☐	☐	☐
Retina	☐	☐	☐
Macular Degeneration	☐	☐	☐
Lazy Eye	☐	☐	☐
Eye Injury	☐	☐	☐
Other: __________	☐	☐	☐
Head			
Headache/Migraine	☐	☐	☐
Temporal Arteritis	☐	☐	☐
TMJ	☐	☐	☐
Other: __________	☐	☐	☐
Lungs			
COPD	☐	☐	☐
Asthma	☐	☐	☐
Sarcoid	☐	☐	☐
Other: __________	☐	☐	☐
Stomach			
Gerd/Acid Reflux	☐	☐	☐
Gastrointestinal Disease	☐	☐	☐
IBS	☐	☐	☐
Other: __________	☐	☐	☐
Immune			
Lupus	☐	☐	☐
Sjogren's	☐	☐	☐
MS	☐	☐	☐
HIV	☐	☐	☐
Other: __________	☐	☐	☐
Endocrine			
Diabetes (Age Dx:_____)	☐	☐	☐
Grave's Disease	☐	☐	☐
Hypo/Hyper Thyroid	☐	☐	☐
Other: __________	☐	☐	☐
Psychological			
Anxiety/Depression	☐	☐	☐
Other: __________	☐	☐	☐

	Yes	No	Not Sure
Skin			
Psoriasis	☐	☐	☐
Rosacea	☐	☐	☐
Shingles	☐	☐	☐
Other: __________	☐	☐	☐
Ears, Nose & Throat			
Allergies	☐	☐	☐
Hearing Loss/Deaf	☐	☐	☐
Sinus	☐	☐	☐
Hard of Hearing	☐	☐	☐
Heart			
Afib	☐	☐	☐
CAD (Heart Disease)	☐	☐	☐
Hypertension	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Heart Attack	☐	☐	☐
Stroke/TIA	☐	☐	☐
High Cholesterol	☐	☐	☐
Other: __________	☐	☐	☐
Urinary			
Prostate	☐	☐	☐
Kidney Disease	☐	☐	☐
Bladder	☐	☐	☐
Colon	☐	☐	☐
Other: __________	☐	☐	☐
Neurological			
Dementia/Alzheimer's	☐	☐	☐
Brain Injury	☐	☐	☐
Tremor	☐	☐	☐
Brain Disorders/Tumor	☐	☐	☐
Other: __________	☐	☐	☐
Musculoskelatal			
Arthritis (Rheumatoid)	☐	☐	☐
Fibromyalgia	☐	☐	☐
Other: __________	☐	☐	☐

Cancer

Type: ______________________________

Radiation: ______________________________

Chemotherapy: ______________________________