Focus Eye Care
Phone:910-447-2020

Name: Date of Birth: Date:

IF referred, by whom?

How did you hear about us?

I. Review of Systems

1) Mark ALL conditions you are currently treating or have treated in the past

- ❒ None
- ❒ Allergies
- ❒ Anemia
- ❒ Anxiety
- ❒ Arthritis
- ❒ Asthma
- ❒ Benign Prostatic Hyperplasia
- ❒ Bipolar Disorder
- ❒ Blood Clot
- ❒ Cancer (add comments below)
- ❒ Chronic Fatigue
- ❒ Congestive Heart Failure
- ❒ COPD / Breathing Problems
- ❒ Coronary Artery Disease
- ❒ Cataracts
- ❒ Dementia / Memory Loss
- ❒ Depression
- ❒ Diabetes
- ❒ Diverticulosis
- ❒ Eating Disorder
- ❒ Emphysema
- ❒ Fibromyalgia
- ❒ Glaucoma
- ❒ Gout
- ❒ Heart Attack
- ❒ Heart Disease
- ❒ Heartburn / Gastric Reflux
- ❒ Hepatitis
- ❒ High Cholesterol
- ❒ HIV
- ❒ Hypertension
- ❒ Kidney Disease
- ❒ Kidney Stones
- ❒ Leg / Foot Ulcers
- ❒ Liver Disease
- ❒ Obesity
- ❒ Osteoporosis
- ❒ Pneumonia
- ❒ Seizures
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis
- ❒ Ulcers
- ❒ Urinary Tract Infections

Comments:

2) Mark ALL symptoms that you currently suffer from

Constitutional

- ❒ Fevers
- ❒ Chills
- ❒ Sweats
- ❒ Weakness
- ❒ Fatigue
- ❒ Decreased Activity
- ❒ Maliase
- ❒ Unexplained Weight Gain
- ❒ Unexplained Weight Loss
- ❒ Low Sex Drive
- ❒ Difficulty Sleeping

Ears/Nose/Throat/Neck

- ❒ Hearing Problems
- ❒ Ear Pain
- ❒ Sinus Problems
- ❒ Sore Throat
- ❒ Nosebleeds

Respiratory

- ❒ Shortness Of Breath
- ❒ Cough
- ❒ Sputum Production
- ❒ Wheezing

Cardiovascular

- ❒ Chest Pain
- ❒ Palpitations
- ❒ Swelling in Feet
- ❒ Bleeding Disorder
- ❒ Blood Clots
- ❒ Fainting
- ❒ Shortness Of Breath During Sleep

Gastrointestinal

- ❒ Nausea
- ❒ Vomiting
- ❒ Diarrhea
- ❒ Constipation
- ❒ Heartburn
- ❒ Abdominal Pain

Genitourinary/Nephrology

- ❒ Painful Urination
- ❒ Blood in Urine
- ❒ Change in Urine Stream
- ❒ Unusual Discharge
- ❒ Flank Pain
- ❒ Urinary Incontinence

Musculoskeletal

- ❒ Back Pain
- ❒ Neck Pain
- ❒ Joint Pain
- ❒ Muscle Pain
- ❒ Muscle Cramp
- ❒ Muscle Spasm

❒ Gait Disturbances ❒ Joint Stiffness ❒ Joint Swelling
❒ Trauma

Integumentary

❒ Rash ❒ Itching ❒ Lesions
❒ Bruising ❒ Masses, Scars ❒ Moles, Skin Tags

Neurological

❒ Abnormal Balance ❒ Confusion ❒ Numbness
❒ Tingling ❒ Dizziness ❒ Headaches
❒ Loss of Coordination ❒ Memory Loss ❒ Seizures
❒ Tinnitus ❒ Tremors ❒ Vertigo

Psychiatric

❒ Feeling Anxious ❒ Depressed Mood ❒ Suicidal Thoughts
❒ Hallucinations ❒ Stress Problems ❒ Suicidal Planning
❒ Thoughts of Harming Others

Allergic/Immunologic:

❒ Hay Fever ❒ Drug Allergies ❒ Food Allergies
❒ Sneezing ❒ Nasal drainage

II. Ocular Review of Systems

3) Mark ALL new or longstanding symptoms that you suffer from

❒ Loss of Vision ❒ Drooping Eyelid ❒ Dryness
❒ Distance Blur ❒ Prominent Eyes ❒ Excess Tearing
❒ Near Blur ❒ Crossed / Lazy Eye ❒ Redness
❒ Distorted Vision/ Halos ❒ Cataracts ❒ Burning
❒ Loss of Side Vision ❒ Glaucoma ❒ Itching
❒ Double Vision ❒ Macular Degeneration ❒ Sandy / Gritty
❒ Glare ❒ Diabetic retinopathy ❒ Foreign Body Sensation

❒ Headlight Starbursts	❒ Retinal Disease	❒ Mucous Discharge
❒ Poor Night Vision	❒ Retinal Hole/Detachment	❒ Pain
❒ Computer Strain	❒ Eye Injuries	❒ Chronic Eye Infection
❒ Tired Eyes	❒ Flashes / Floaters	❒ Stye / Chalazion

List any other symptoms

4) Do you wear contact lenses? **# hrs/ day** **# days/wk**
Brand / Rx

III. Medical and Surgical History

5) List additional medical and surgical history

6) List any allergies, including your reaction (Ex. short of breath, hives)

7) List or update any current prescription medications you are taking

8) List any vitamins, herbals, supplements, or over the counter medications

IV. Family History

9) Mark ALL known family health conditions

	Mother	Father	Sister	Brother	Daughter	Son
Arthritis	❒	❒	❒	❒	❒	❒
Asthma	❒	❒	❒	❒	❒	❒
Dementia	❒	❒	❒	❒	❒	❒
Depression	❒	❒	❒	❒	❒	❒
Diabetes - Type I	❒	❒	❒	❒	❒	❒
Diabetes - Type II	❒	❒	❒	❒	❒	❒
Heart Disease	❒	❒	❒	❒	❒	❒
High Blood Pressure	❒	❒	❒	❒	❒	❒
High Cholesterol	❒	❒	❒	❒	❒	❒
Kidney Disease	❒	❒	❒	❒	❒	❒
Obesity	❒	❒	❒	❒	❒	❒
Osteoporosis	❒	❒	❒	❒	❒	❒
Stroke	❒	❒	❒	❒	❒	❒
Substance Abuse	❒	❒	❒	❒	❒	❒
Cancer (add comments below)	❒	❒	❒	❒	❒	❒
Macular Degeneration	❒	❒	❒	❒	❒	❒
Glaucoma	❒	❒	❒	❒	❒	❒
Blindness	❒	❒	❒	❒	❒	❒
Retinal Detachment	❒	❒	❒	❒	❒	❒

Additional Comments (Please note if grandparents suffered from any eye disease):

V. Social History

10) Select your tobacco status # Years smoking If you quit, when?

11) How often you do drink alcohol?

12) List any illegal substances you use.

13) Do you exercise? Frequency:

minutes per day for days a week

14) What is your marital status?

15) How many kids do you have?

16) What is your occupation?

17) List any special interests or hobbies

18) Did you get a flu shot this year?

Thank you for taking the time to complete this medical history, and for the trust you have placed in us. We look forward to seeing you!