Patient Name: _____ DOB: _____

Male **Female**

Preferred Language: _____ Marital Status: _____

Race: _____ Citizenship: _____

Ethnicity: *Hispanic or Latino* Yes No

RFV

Reason For Visit Today: _____

ROS

Review of Systems

Constitutional

- Developmental Disabilities ☐
- Cancer ☐
- Fatigue Syndrome ☐
- Other: _____ ☐

Ear / Nose / Throat

- Hearing Loss ☐
- Sinusitis ☐
- Dry Mouth ☐
- Laryngitis ☐
- Other: _____ ☐

Neurological

- Multiple Sclerosis ☐
- Epilepsy ☐
- Cerebral Palsy ☐
- Tumor ☐
- Stroke / CVA / TIA ☐
- Migraines ☐
- Other: _____ ☐

Psychiatric

- Depression ☐
- Attention Deficit ☐
- Anxiety Disorder ☐
- Bipolar Disorder ☐
- Other: _____ ☐

Cardiovascular

- Hypertension (HBP) ☐
- Stroke / CVA ☐
- Heart Disease ☐
- Vascular Disease ☐
- Congestive Heart Failure ☐
- Other: _____ ☐

Respiratory

- Cigarette Smoker ☐
- Asthma ☐
- Bronchitis ☐
- Emphysema ☐
- Chronic Obstruction ☐
- Sleep Apnea ☐
- Other: _____ ☐

Gastrointestinal

- Chrohn's ☐
- Colitis ☐
- Ulcer ☐
- Acid Reflux ☐
- Celiac Disease ☐
- Other: _____ ☐

Genitourinary

- Kidney Disease ☐
- Prostate Disease / Cancer ☐
- STD-Herpetic / Chlamydia ☐
- Benign Prostate Hypertrophy ☐
- Pregnant ☐
- Nursing ☐
- Herpes ☐
- Chlamydia ☐
- Other: _____ ☐

Musculoskeletal

- Arthritis ☐
- Osteoarthritis ☐
- FibroMyalgia ☐
- Muscular Dystrophy ☐
- Ankylosing Spondylitis ☐
- Osteoporosis ☐
- Gout ☐
- Other: _____ ☐

Integumentary

- Eczema ☐
- Rosacea ☐
- Psoriasis ☐
- Herpes Simplex / Cold Sores ☐
- Herpes Zoster / Shingles ☐
- Other: _____ ☐

Endocrine

- Type 2 Diabetes Mellitus ☐
- Type 1 Diabetes Mellitus ☐
- Thyroid Dysfunciton ☐
- Hormonal Dysfunction ☐
- Other: _____ ☐

Hemotologic / Lymphatic

- Anemia ☐
- Large-Volume Blood Loss ☐
- Ulcer ☐
- Hypercholesteremia (cholesterol) ☐
- Other: _____ ☐

Allergic / Immune

- Drug Allergies ☐
- Enviromental Allergies ☐
- Rheumatioid Arthritis ☐
- Lupus ☐
- Sjogren's Syndrome ☐
- Other: _____ ☐

Medications

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

_____ mg

Please Update Medical History

Richard D. Hamilton, OD **Allan O. Dean, OD**

Drug Allergies

Other Allergies
Latex Sensitivity
Yes or No

Adopted ☐

Family History

Please review the conditions below and chose the person in relation to you.

Family Medical Conditions

Cancer	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

Diabetes	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

Hypertensive/Blood Pressure	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

Family Eye Conditions

Cataract	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

Macular Degeneration	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

Glaucoma	
Father	
Mother	
Brother	
Sister	
Son	
Daughter	

PFSH

Past Ocular History

Glaucoma	
Glaucoma Suspect	
Cataract	
Age-Related Macular Degeneration	
Surgery	
Patching	
Inflammatory Disorder	
Strabismus (Crossed Eyes)	
Amblyopia (Lazy Eye)	
Retinal Degeneration / Hole	
Retinal Degeneration	
Retinal Hole	
Retinal Detachment	
Keratoconus	
Injury	
Other: _____	

Social History

Drinking Y N

Amount _____

Tobacco Use	Y	N
Smokes Cigarettes		
Smokes Cigars		
Smokes Pipe		
Smokes Other		
Smokeless Tobacco		

Amount _____

Current Smoking Status	
Never Smoker	
Former Smoker	
Some Day Smoker (social)	
Every Day Smoker	

Comments

Hobbies

Are you a Contact Lens Wearer? Y N

What type of Contact Lenses:

Soft or Gas Perm/Hard

please circle one

Soft Contact Lens Brand

example: Acuvue Oasys

Powers/RX *example: -2.00*

Right: _____

Left: _____

Type of Contact Lens Solution

New Healthcare Requirements

Full Eye Exam Visits Only

Vital Signs Information

Height: _____

Weight: _____