

20/20 OPHTHALMIC ASSOCIATES, P.C.

Please Answer All Questions

Date: _____ Name: _____ Date of Birth: _____

Occupation: _____ Medical Dr. _____

Review of Systems: (Do you **currently** have problems with any of the following?):

- Y N
- ____ Ears, Nose, Mouth, Throat
- ____ Cardiovascular System (Heart & Blood Vessels)
- ____ Respiratory System (Lungs)
- ____ Genito-urinary System (Urination, Sexual organs)
- ____ GI System (Digestion)
- ____ Bones, Joints, Muscles
- ____ Skin
- ____ Neurologic System
- ____ Hematologic/Lymphatic (Blood disorders/cancers)
- ____ Psychiatric System
- ____ Endocrine (Thyroid, Pituitary, Reproductive glands)
- ____ Allergic/Immunologic (Autoimmune diseases like Lupus, Rheumatoid Arthritis)

If yes, describe: _____

Past Medical History:

	Y	N	Comments
Arthritis			
Cancer			
Diabetes			
Heart:			
Chest Pain			
Heart Attack			
Congestive Failure			
High Blood Pressure			
Kidneys			
Stones			
Dialysis			
Lungs			
Asthma			
Emphysema			
Stroke			
Trauma			
Other			

Past Eye History:

Do you wear glasses? Y / N Contact lenses? Y / N

	Y	N	Comments/Dates
Amblyopia ("lazy eye")			
Strabismus (e.g. crossed eyes)			
Retinal Detachment			
Glaucoma			
Trauma			
Cataract Surgery			
Right Eye			
Left Eye			
Other			

Family History:

	Y	N	Which relative?
Blindness	____	____	_____
Strabismus	____	____	_____
Diabetes	____	____	_____
Glaucoma	____	____	_____
Retinal Detachment	____	____	_____
Other:	_____	_____	_____

Social History:

Smoke: Y____ N____ Alcohol: Y____ N____
 Drive: Y____ N____ Drugs: Y____ N____
 Comments: _____

Drug Allergies: _____

Have you had any surgeries? Yes No

Medications:

Drugstore: _____ Number: _____

<i>Office Use Only</i>	
Reviewed/Date: _____ / _____	Reviewed/Date: _____ / _____
_____ / _____	_____ / _____
_____ / _____	_____ / _____
HRT	Visual Field
_____	_____
_____	_____
_____	_____
_____	_____