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:

_____

_____

_____

_____

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_____

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_____

_____

_____

Drugstore: Number:

Office Use Only

Reviewed/Date:	Reviewed/Date:
___/___	___/___
___/___	___/___
___/___	___/___
HRT	**Visual Field**
_____	_____
_____	_____
_____	_____
_____	_____