Jennifer Fishel, OD & Associates is pleased to be your eye care provider. Please complete this form and answer all questions to the best of your ability or note any changes since your last visit. We will review this information with you during your examination.

Name: ______________________ Date of birth: ____/____/____ Last eye exam ____/____/____

Family Doctor: ______________________ Other Doctor: ______________________

| | | | | | |
|---|---|---|---|---|---|
| Loss of vision | Y / N | Dryness | Y / N | Excess tearing/watering | Y / N |
| Blurred vision | Y / N | Mucous discharge | Y / N | Glare/light sensitivity | Y / N |
| Fluctuating vision | Y / N | Sandy/gritty feeling | Y / N | Eye pain/soreness | Y / N |
| Distorted vision (Halos) | Y / N | Itching | Y / N | Infection of the eyelid | Y / N |
| Loss of side vision | Y / N | Burning | Y / N | Flashes of light/floaters | Y / N |
| Double vision | Y / N | Foreign body sensation | Y / N | Headaches | Y / N |

***Complete the short section above and then if nothing has changed sign and date below.***

**If nothing else has changed since your last visit please sign and date here:** ______________________ Date __________

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**Current Medications** (prescribed and over the counter)

__________ __________
__________ __________
__________ __________
__________ __________

**Allergies to medications:**

**Current Eye Medications, Dose, Frequency**

**Right eye:** ______________________

Last used? ______________________

**Left eye:** ______________________

Last used? ______________________

**Surgeries (any):**

**Your Past Ocular History**

| | |
|---|---|
| Glaucoma | Y / N |
| Cataract | Y / N |
| Macular degeneration | Y / N |
| Diabetic eye disease | Y / N |
| Trauma | Y / N |
| Retinal detachment | Y / N |
| Lazy eye | Y / N |
| Eye surgery | Y / N |
| Laser treatment | Y / N |

| Your Family Ocular History | | Which family member? |
|---|---|---|
| Glaucoma | Y / N | __________ |
| Cataract | Y / N | __________ |
| Macular degeneration | Y / N | __________ |
| Diabetic eye disease | Y / N | __________ |
| Retinal detachment | Y / N | __________ |
| Blindness | Y / N | __________ |

Other: ______________________

**Your Social History**

| | | |
|---|---|---|
| Smoking | Y / N | Packs per day? __________ |
| Alcohol | Y / N | Drinks per day? __________ |

| Your Family History | | Which family member? |
|---|---|---|
| Arthritis | Y / N | __________ |
| Cancer | Y / N | __________ |
| Diabetes | Y / N | __________ |
| Heart Disease | Y / N | __________ |
| Kidney Disease | Y / N | __________ |

| Your Family History | | Which family member? |
|---|---|---|
| High BP | Y / N | __________ |
| Lupus | Y / N | __________ |
| Stroke | Y / N | __________ |
| Thyroid Disease | Y / N | __________ |
| Other | Y / N | __________ |

**Turn over ↓**

**Constitutional**
Flu Y / N
Fever Y / N
Fatigue Y / N

**Ear, Nose, Throat**
Hearing problems Y / N
Sinus Y / N
Throat Y / N

**Cardiovascular**
Chest pain Y / N
Palpitations Y / N
High blood pressure Y / N
Heart failure Y / N
Pacemaker Y / N
Heart Attack Y / N
Angioplasty / bypass Y / N
Valve disease Y / N
Carotid artery disease Y / N

**Respiratory**
Shortness of breath Y / N
Asthma Y / N
Emphysema Y / N
Cough Y / N
Bronchitis Y / N
Pneumonia Y / N
Tuberculosis Y / N

**Gastrointestinal**
Heartburn Y / N
Bowel problems Y / N
Hepatitis Y / N
Inflamed bowel disease Y / N

**Skin**
Rash Y / N
Itch Y / N
Lesions Y / N
Growth / tumors Y / N

**Musculoskeletal**
Joint pain Y / N
Rheumatoid arthritis Y / N
Back pain Y / N
Fractures Y / N

**Musculoskeletal** (continued)
Marfan's syndrome Y / N
Ankylosing spondylitis Y / N

**Neurological**
Stroke Y / N
Weakness Y / N
Seizures Y / N
Multiple sclerosis Y / N

**Hematologic**
Anemia Y / N
Sickle cell Y / N
Bleeding abnormality Y / N
Elevated cholesterol Y / N

**Immunology**
AIDS Y / N
HIV Y / N
Immune deficiency Y / N
Lupus Y / N
Sjogren's Y / N

Other ____________________

**Psychiatric**
Dementia Y / N
Alzheimer's Y / N
Depression Y / N
Anxiety Y / N
Schizophrenia Y / N

**Genitourinary**
Prostate Y / N
Kidney stones Y / N
Hysterectomy Y / N
Pregnant currently Y / N

**Endocrine**
Thyroid Y / N
Diabetes Y / N

If yes, how many years:____________

Last blood sugar level:____________

**Cancer** Y / N

If yes, what type? ____________

Do you have difficulty when driving? Y / N
Do you have problems with night vision? Y / N
Do you currently wear glasses? Y / N
Do you currently wear contacts? Y / N

Would you like to be fit in contacts? Y / N

Do you have eye strain with computer use? Y / N
Would you like information on refractive surgery? Y / N

**FOR OFFICE USE ONLY**

Signature of Technician who reviewed history: ____________________ Date ____/____/____
Signature of Doctor who reviewed history: ____________________ Date ____/____/____