

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Past Ocular History**

\_\_\_ No Ocular History

- |                                |           |          |
|--------------------------------|-----------|----------|
| Branch Retinal Vein Occlusion  | Right Eye | Left Eye |
| Cataract                       | Right Eye | Left Eye |
| Central Retinal Vein Occlusion | Right Eye | Left Eye |
| Corneal Transplant             | Right Eye | Left Eye |
| Diabetic Retinopathy           | Right Eye | Left Eye |
| Epiretinal Membrane            | Right Eye | Left Eye |
| Eye Infection                  | Right Eye | Left Eye |
| Eye Trauma                     | Right Eye | Left Eye |
| Glaucoma                       | Right Eye | Left Eye |
| Lens Implants                  | Right Eye | Left Eye |
| Macular Degeneration           | Right Eye | Left Eye |
| Macular Hole                   | Right Eye | Left Eye |
| Melanoma                       | Right Eye | Left Eye |
| Retinal Detachment             | Right Eye | Left Eye |
| Retinopathy of Prematurity     | Right Eye | Left Eye |

**Ocular Procedures**

\_\_\_ No Ocular Procedures

- |                         |           |          |
|-------------------------|-----------|----------|
| Avastin Injection       | Right Eye | Left Eye |
| Cataract Surgery        | Right Eye | Left Eye |
| Corneal Transplant      | Right Eye | Left Eye |
| Enucleation             | Right Eye | Left Eye |
| Eylea Injection         | Right Eye | Left Eye |
| Lasik                   | Right Eye | Left Eye |
| Lucentis Injection      | Right Eye | Left Eye |
| Muscle Eye Disease      | Right Eye | Left Eye |
| Radiation               | Right Eye | Left Eye |
| Removal of Foreign Body | Right Eye | Left Eye |
| Retinal Laser Surgery   | Right Eye | Left Eye |
| Retinal Surgery         | Right Eye | Left Eye |
| YAG Laser               | Right Eye | Left Eye |

**Significant to Ocular**

\_\_\_ NONE

- |                       |                                 |
|-----------------------|---------------------------------|
| <u>___ Aging</u>      | <u>___ High Blood Pressure</u>  |
| <u>___ AIDS/ HIV</u>  | <u>___ Lupus</u>                |
| <u>___ Diabetes</u>   | <u>___ Macular Degeneration</u> |
| <u>___ Eye Trauma</u> | <u>___ Melanoma</u>             |
| <u>___ Glaucoma</u>   | <u>___ Rheumatoid Arthritis</u> |

**Infections Systemic**

\_\_\_ Overall Healthy

- |                                   |                               |
|-----------------------------------|-------------------------------|
| <u>___ AIDS / HIV</u>             | <u>___ Meningitis – viral</u> |
| <u>___ Chicken Pox</u>            | <u>___ Mumps</u>              |
| <u>___ Cold Sores</u>             | <u>___ Pancreatitis</u>       |
| <u>___ Diphtheria</u>             | <u>___ Rheumatic Fever</u>    |
| <u>___ Hepatitis A</u>            | <u>___ Scarlet Fever</u>      |
| <u>___ Hepatitis B</u>            | <u>___ STD's</u>              |
| <u>___ Hepatitis C</u>            | <u>___ Shingles</u>           |
| <u>___ Histoplasmosis</u>         | <u>___ Syphilis</u>           |
| <u>___ Malignant Melanoma</u>     | <u>___ Tuberculosis</u>       |
| <u>___ Measles</u>                | <u>___ Wound Infections</u>   |
| <u>___ Meningitis – bacterial</u> |                               |

**System Illnesses**

\_\_\_ No History of Illness/Overall Healthy

- |                                |                                 |
|--------------------------------|---------------------------------|
| <u>___ AIDS/HIV</u>            | <u>___ Kidney Disease</u>       |
| <u>___ Alzheimers</u>          | <u>___ Liver Disease</u>        |
| <u>___ Anemia</u>              | <u>___ Lupus</u>                |
| <u>___ Asthma</u>              | <u>___ Lymphoma</u>             |
| <u>___ Breast Cancer</u>       | <u>___ Migraine</u>             |
| <u>___ Cancer</u>              | <u>___ Multiple Sclerosis</u>   |
| <u>___ Colitis</u>             | <u>___ Parkinson's</u>          |
| <u>___ Colon Cancer</u>        | <u>___ Pneumonia</u>            |
| <u>___ COPD</u>                | <u>___ Prostate Cancer</u>      |
| <u>___ Down Syndrome</u>       | <u>___ Psychiatric Disorder</u> |
| <u>___ Epilepsy</u>            | <u>___ Rheumatic Fever</u>      |
| <u>___ Fibromyalgia</u>        | <u>___ Skin Cancer</u>          |
| <u>___ GERD</u>                | <u>___ Stomach Ulcers</u>       |
| <u>___ Headache</u>            | <u>___ Stroke</u>               |
| <u>___ Heart Attack</u>        | <u>___ TB</u>                   |
| <u>___ Heart Disease</u>       | <u>___ Thyroid Disease</u>      |
| <u>___ Hepatitis</u>           | <u>___ Type 1 Diabetes</u>      |
| <u>___ High Blood Pressure</u> | <u>___ Type 2 Diabetes</u>      |
| <u>___ IBS</u>                 |                                 |

**Eye Drops or Eye Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

VUELTA PARA ESPANOL

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**Head/Ocular Trauma**

- No Head or Ocular Trauma
- Assaulted with Head involvement
- Assaulted with Ocular involvement
- Blunt force head trauma
- Motor vehicle accident
- Ocular blunt trauma
- Ocular chemical injury
- Ocular foreign body – metal
- Ocular foreign body – mineral
- Ocular foreign body – organic
- Ocular foreign body – plastic
- Ocular injury
- Ocular injury with sharp object
- Ocular injury with head involvement
- Firearm related injury with head involvement
- Job injury with head involvement
- Job injury with ocular involvement

**General Surgeries**

- No Prior Surgery
- Appendectomy
- Back Surgery
- Brain Surgery
- Breast Augmentation
- Cesarean Section
- Colectomy
- Gallbladder Surgery
- Gastric Stapling
- GI Surgery
- Heart Stents
- Heart Surgery
- Heart Transplant
- Hip Replacement
- Hysterectomy
- Kidney Transplant
- Knee Surgery
- Lung Surgery
- Mastectomy
- Pacemaker
- Pancreas Transplant
- Plastic Surgery
- Prostate Surgery
- Shoulder Surgery
- Thyroidectomy
- Vasectomy

**Current Medications**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Allergies and Drug Reactions**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Social History**

Smoking Status:  Daily Smoker  Occasionally Smokes  Former Smoker  Never Smoked

Alcohol Status:  Socially Drinker  Occasionally Drinks  Daily Drinker  Never Drinks

Street Drug Use:  NO  YES (if yes explain) \_\_\_\_\_

Do you live alone?  NO  YES

Do you drive?  NO  YES