

# LIVINGSTON EYE CARE

## Patient History and Information

Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ (We will only use your e-mail to notify you of specials)

Referred By: \_\_\_\_\_ Facebook, Commercial, Pennysaver, Other: \_\_\_\_\_

### Health History

What is the main reason for today's exam? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ When was your last health exam? \_\_\_\_\_

Past Illnesses or Injuries \_\_\_\_\_

Past Surgeries \_\_\_\_\_

Current Medications \_\_\_\_\_

Allergies \_\_\_\_\_ Current Eye Drops \_\_\_\_\_

### Eye History

	Y	N		Y	N		Y	N
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (Crossed Eyes)	<input type="checkbox"/>	<input type="checkbox"/>
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision Distance	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision Near	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision (Halos)	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Itching	<input type="checkbox"/>	<input type="checkbox"/>	Floaters or Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Drooping Eyelid	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

### Personal Health History

	Y	N		Y	N		Y	N
Anxiety or Depression	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Excess Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>	Illegal Drug Use	<input type="checkbox"/>	<input type="checkbox"/>
Muscle, Bones, Joints	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine/Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use	<input type="checkbox"/>	<input type="checkbox"/>
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular/HBP	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	STD's	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood/Lymph	<input type="checkbox"/>	<input type="checkbox"/>						

### Family History

	Y	N		Y	N		Y	N
Amblyopia (Lazy Eye)	<input type="checkbox"/>	<input type="checkbox"/>	Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Strabismus (Eye Turn)	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cataract(s)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Color Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>