HORIZON EYE PHYSICIANS

PATIENT'S NAME: _____ DOB: _____
TODAY'S DATE: _____

Reason for visit: _____

If you wear eyeglasses, how old were you when you started wearing them? _____
How old is your current prescription? _____
If you wear contact, how old is the prescription? _____
How many hours a day do you wear them? _____
What is the approximate date of your last dilated eye exam? _____
Who did the exam? _____

Pharmacy Name: _____
Address: _____
Phone Number: _____

REVIEW OF SYSTEMS- PLEASE CHECK EITHER YES OR NO *DO NOT LEAVE ANY BLANK*

MEDICAL HISTORY:

YES NO: Have **you** ever been told you have?

☐ ☐ Blindness
☐ ☐ Cataracts
☐ ☐ Diabetic Retinopathy
☐ ☐ Glaucoma
☐ ☐ Macular Degeneration
☐ ☐ Retinal Detachment/Disease

☐ Other: _____

YES NO: Have **You** ever been told you have?

☐ ☐ Rheumatoid Arthritis
☐ ☐ Cancer
☐ ☐ Diabetes- Adult Onset
☐ ☐ Diabetes-Childhood Onset
☐ ☐ Heart Disease
☐ ☐ High Blood Pressure
☐ ☐ High Cholesterol
☐ ☐ Kidney Disease
☐ ☐ Lung Breathing Disease
☐ ☐ Lupus Multiple Sclerosis

YES NO:

☐ ☐ Stroke
☐ ☐ Graves/Thyroid Disease
☐ ☐ Sleep Apnea and use of CPAP
☐ ☐ HIV/Aids
☐ ☐ Malignant hypothermia
☐ ☐ Psychiatric Disorder
☐ ☐ Parkinson's Disease
☐ ☐ Renal Failure
☐ ☐ Skin Disease
☐ ☐ To take antibiotics prior to dental work or surgery?

☐ Other: _____

FAMILY HISTORY:

YES NO: Has anyone in your family ever been told they have? If so please list the relationship

☐ ☐ Blindness _____
☐ ☐ Cataracts _____
☐ ☐ Diabetic Retinopathy _____
☐ ☐ Glaucoma _____
☐ ☐ Macular Degeneration _____
☐ ☐ Retinal Detachment/Disease _____

☐ Other: _____

YES NO: Has anyone in your family ever been told they have? If so please list the relationship

☐ ☐ Rheumatoid Arthritis _____
☐ ☐ Cancer _____
☐ ☐ Diabetes- Adult Onset _____
☐ ☐ Diabetes-Childhood Onset _____
☐ ☐ Heart Disease _____
☐ ☐ High Blood Pressure _____
☐ ☐ High Cholesterol _____
☐ ☐ Kidney Disease _____
☐ ☐ Lung Breathing Disease _____
☐ ☐ Lupus Multiple Sclerosis _____
☐ ☐ Stroke _____
☐ ☐ Graves/Thyroid Disease _____
☐ ☐ Sleep Apnea and use of CPAP _____
☐ ☐ HIV/Aids _____
☐ ☐ Malignant hypothermia _____
☐ ☐ Psychiatric Disorder _____
☐ ☐ Parkinson's Disease _____
☐ ☐ Renal Failure _____
☐ ☐ Skin Disease _____
☐ ☐ To take antibiotics prior to dental work or surgery?

☐ Other: _____

DO YOU?

Currently Smoke (including vaping)? ☐ YES ☐ NO **If YES then Start Date:** _____

Past Smoker? (including vaping)? ☐ YES ☐ NO **If YES then Dates:** _____

Use recreational drugs ☐ YES ☐ NO

Alcohol use ☐ Daily ☐ Occasionally ☐ None

Have you previously had cataract surgery or any eye surgeries or injuries (what, when)

_____
_____
_____
_____

Have you had any health-related surgeries or injuries? If so what was the issue/surgery, and when did this occur?

_____
_____
_____
_____
_____

PATIENT'S NAME: _____

DATE_____

PLEASE LIST THE MEDICATIONS (INCLUDING OVER THE COUNTER) YOU TAKE

Medication Name; Dosage & Use (if known)	Reason Taking Med

Are you allergic to latex? ☐ YES ☐ NO

PLEASE LIST ANY ALLERGIES TO MEDICATIONS

_____

_____

_____

_____

REVIEW OF SYSTEMS

YES NO: Do **you** have?

☐ ☐ Loss Of Vision
☐ ☐ Fluctuated Vision
☐ ☐ Loss of Side Vision
☐ ☐ Dryness
☐ ☐ Redness
☐ ☐ Burning or itchy
☐ ☐ Excess Tearing and Watering
☐ ☐ Eye Pain or Soreness
☐ ☐ Tired Eyes
☐ ☐ Lazy Eyes
☐ ☐ Blurred Vision
☐ ☐ Distorted Vision
☐ ☐ Double Vision
☐ ☐ Mucus
☐ ☐ Sandy or Gritty Feeling
☐ ☐ Glare and Light Sensitivity
☐ ☐ Infection of Eyelid
☐ ☐ Crossing Eyes
☐ ☐ Drooping Eyelid

RECENTLY HAD:

A fever ☐ YES ☐ NO

Unusual Tiredness ☐ YES ☐ NO

Blood Transfusion ☐ YES ☐ NO

Unintentional weight loss ☐ YES ☐ NO

How tall are you?:_____ What is your approximate weight?: _____