

# Sunset Eye Clinic, LLC

## 1. PATIENT INFORMATION

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date: \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Last Medical Exam \_\_\_\_\_  
Medical Doctor's Name \_\_\_\_\_ Dr's Phone Number \_\_\_\_\_

## 2. EYE HEALTH HISTORY (Please check any symptom / condition that applies)

- |  |  |   |   |   |
|--|--|---|---|---|
| <input type="checkbox"/> Need new glasses / contact lens | <input type="checkbox"/> Lazy Eyes           | <input type="checkbox"/> Flashes/floaters in vision | <input type="checkbox"/> Itchy Eyes               | <input type="checkbox"/> Cataracts            |
| <input type="checkbox"/> Blurry Distance Vision          | <input type="checkbox"/> Double Vision       | <input type="checkbox"/> Temporary Vision Loss      | <input type="checkbox"/> Watery Eyes              | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Blurry Near Vision              | <input type="checkbox"/> Loss of side Vision | <input type="checkbox"/> Foreign Body sensation     | <input type="checkbox"/> Burning                  | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Tired Eyes                      | <input type="checkbox"/> Headache            | <input type="checkbox"/> Dry Eyes                   | <input type="checkbox"/> Infection                | <input type="checkbox"/> Eye Injury           |
| <input type="checkbox"/> Computer Eye Strain             | <input type="checkbox"/> Light Sensitivity   | <input type="checkbox"/> Redness                    | <input type="checkbox"/> Sties                    | <input type="checkbox"/> Other                |
|  |  |   | <input type="checkbox"/> Lasik/Refractive Surgery |   |

Date of Last Eye Exam: \_\_\_\_\_ Do you wear contact lenses (Y / N) Are you interested in contact lenses (Y / N)  
Do you wear glasses (Y / N) Do you use a computer regularly (Y / N), if so, how many hours: \_\_\_\_\_

## 3. Review of Systems (Do you currently, or have you ever had any problems in the following areas, check all that apply)

- |   |  |   |  |   |
|---|--|---|--|---|
| <b>Constitutional</b>                         | <b>Ear, Nose, Throat, Mouth</b>              | <b>Respiratory</b>                          | <input type="checkbox"/> High Blood Pressure | <b>Bones/Joints/Muscles</b>                   |
| <input type="checkbox"/> Fever                | <input type="checkbox"/> Allergies/Hay Fever | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Vascular Disease    | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Weight Loss          | <input type="checkbox"/> Sinus Congestion    | <input type="checkbox"/> Chronic Bronchitis | <b>Gastrointestinal</b>                      | <input type="checkbox"/> Muscle Pain          |
| <input type="checkbox"/> Weight Gain          | <input type="checkbox"/> Runny Nose          | <input type="checkbox"/> Emphysema          | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Joint Pain           |
| <b>Endocrine</b>                              | <input type="checkbox"/> Post-Nasal Drip     | <b>Vascular</b>                             | <input type="checkbox"/> Constipation        | <b>Lymphatic/Hematologic</b>                  |
| <input type="checkbox"/> Thyroid/other glands | <input type="checkbox"/> Chronic Cough       | <input type="checkbox"/> Diabetes           | <b>Genitourinary</b>                         | <input type="checkbox"/> Anemia               |
| <b>Psychiatric</b>                            | <input type="checkbox"/> Dry Throat/ Mouth   | <input type="checkbox"/> Heart Pain         | <input type="checkbox"/> Kidney/Bladder      | <input type="checkbox"/> Bleeding Problems    |
| _____   | <b>Allergic/Immunologic</b>                  | <input type="checkbox"/> High Cholesterol   | <b>Integumentary/Skin</b>                    | _____   |

If you answered YES to any of the above or have a condition not listed, please explain: \_\_\_\_\_

List any medications you take including birth control, over the counter medications, eye drops, and home remedies:  
\_\_\_\_\_  
\_\_\_\_\_

Allergies to any medications: \_\_\_\_\_ Are you pregnant/Nursing (Y / N)

## 4. FAMILY HISTORY (Please check if your relatives had / have any of the following conditions)

- Blindness  Crossed Eyes  Retinal Problems  High Blood Pressure  Cataract  Glaucoma  Arthritis  
 Macular Degeneration  Diabetes  Kidney Disease  Cancer  Thyroid Disease  Lupus  Other

## 5. Social History (This information is kept confidential. However, you may discuss this portion with the doctor.)

Do you drive?  No  Yes If yes, do you have visual difficulty when driving?  No  Yes

Do you use cigarettes/tobacco? \_\_\_\_\_ Alcohol? \_\_\_\_\_ Other Substances? \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis

Doctor's Signature \_\_\_\_\_