Hill
Family Eye Center, Inc.

Date:_____

First Name:_____ M.I.:_____ Last Name:_____ DOB:_____

Last Eye Exam_____ Doctor_____ Findings_____

Last Medical Exam_____ Doctor_____

List any **medications** you take (include oral contraceptives, aspirin, and over the counter medications) ☐ None

1. _____ 4. _____ 7. _____ 10. _____
2. _____ 5. _____ 8. _____ 11. _____
3. _____ 6. _____ 9. _____ 12. _____

List any injuries, surgeries, or traumas to your **eyes**: ☐ None

1. _____ 3. _____
2. _____ 4. _____

List all **major** injuries, surgeries, and/or hospitalizations you have had: ☐ None

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any drug **allergies** you have: ☐ None

1. _____ 3. _____
2. _____ 4. _____

Check any of the following that you have been diagnosed with or treated for: ☐ None

☐ Crossed Eye ☐ Glaucoma ☐ Drooping Eye Lid ☐ Cataracts ☐ Uveitis

☐Lazy Eye ☐ Retinal Disease ☐ Prominent Eyes ☐ Chronic Eye Infection

Review Of Systems

Neurologic

Headaches	☐ YES	☐ NO	_____
Migraines	☐ YES	☐ NO	_____
Seizures	☐ YES	☐ NO	_____

Vascular

Diabetes	☐ YES	☐ NO	_____
Heart Pain	☐ YES	☐ NO	_____
High Blood Pressure	☐ YES	☐ NO	_____
Vascular Disease	☐ YES	☐ NO	_____
High Cholesterol	☐ YES	☐ NO	_____

Ear,Nose,Throat,Mouth

Allergies	☐ YES	☐ NO	_____
Hay Fever	☐ YES	☐ NO	_____
Sinus Congestion	☐ YES	☐ NO	_____

Bones/Joints/Muscles

Rheumatoid Arthritis	☐ YES	☐ NO	_____
Muscle/Joint Pain	☐ YES	☐ NO	_____
Connective Tissue Disease	☐ YES	☐ NO	_____

Cont'd Name_____ Date_____

Eyes

Blurred Vision	☐ YES	☐ NO	_____
Loss of Side Vision	☐ YES	☐ NO	_____
Decreased Central Vision	☐ YES	☐ NO	_____
Double Vision	☐ YES	☐ NO	_____
Tired Eyes	☐ YES	☐ NO	_____
Glare/Light Sensitivity	☐ YES	☐ NO	_____
Halos Around Lights	☐ YES	☐ NO	_____
Dryness	☐ YES	☐ NO	_____
Mucous Discharge	☐ YES	☐ NO	_____
Redness	☐ YES	☐ NO	_____
Sandy/Gritty Feeling	☐ YES	☐ NO	_____
Itching	☐ YES	☐ NO	_____
Burning	☐ YES	☐ NO	_____
Foreign Body Sensation	☐ YES	☐ NO	_____
Tearing/Watering	☐ YES	☐ NO	_____
Eye Pain/Soreness	☐ YES	☐ NO	_____
Stye/Chalazion	☐ YES	☐ NO	_____
Seeing Flashes of Light	☐ YES	☐ NO	_____
Seeing Floaters	☐ YES	☐ NO	_____
Chronic Infection	☐ YES	☐ NO	_____
Lymphatic/Hematalogic			
Anemia/Sickle Cell	☐ YES	☐ NO	_____
Bleeding	☐ YES	☐ NO	_____
Endocrine			
Thyroid/Other	☐ YES	☐ NO	_____
Psychiatric			
Depression/Other	☐ YES	☐ NO	_____
Respiratory			
Asthma	☐ YES	☐ NO	_____
Chronic Bronchitis	☐ YES	☐ NO	_____
Emphysema	☐ YES	☐ NO	_____

Family History

Please note any family member (**immediate blood relatives**, living or deceased) who have had the following:

Blindness	☐ YES	☐ NO	_____	Cataract	☐ YES	☐ NO	_____
Retinal Disease	☐ YES	☐ NO	_____	Glaucoma	☐ YES	☐ NO	_____
Macular Degeneration	☐ YES	☐ NO	_____	Diabetes	☐ YES	☐ NO	_____
High Blood Pressure	☐ YES	☐ NO	_____	Cancer	☐ YES	☐ NO	_____

Other:_____

Social History

Do you smoke	☐ YES	☐ NO	_____	Illegal drugs	☐ YES	☐ NO	_____
Do you drink alcohol	☐ YES	☐ NO	_____				
Pregnant	☐ YES	☐ NO	_____	Breast Feeding	☐ YES	☐ NO	_____

Dr. Sig_____

Date:_____