PATIENT NAME:
DATE:
DATE OF BIRTH:

Brunswick Eye Care Associates

Your Past/Present Eye History		
Yes	**No**	
		Diabetic Eye Disease
		Glaucoma
		Macular Degeneration
		Cataracts
		Cataract Surgery
		Laser Surgery RK, LASIK, Other:
		Eye Injury (Explain):
		Crossed or Lazy Eye
		Retinal Detachment
		Other:

Your Social History		
Yes	**No**	
		Drink Alcohol?
		Use Medical Marijuana?
		Drink Caffeinated Beverages?
		Smoke?
		If quit smoking, at what age?

Family Medical History Have your parents, brothers, sisters and/or grandparents ever been affected by any of the following? Please check yes or no to each.		
Yes	**No**	
		Diabetes
		Macular Degeneration
		Glaucoma
		Retinal Detachment
		Blindness
		Bleeding or Blood Clotting Issues
		Tumors of the Eye
		Heart/Cardiovascular Disease
		Other:

Medications you are currently taking

PAST SURGERIES:

ALLERGIES:

*****Turn page over to complete form*****

Review of Systems

Do you have or have you had any of the following? Please check appropriate response in every box.

Yes	No	Ears, Nose, Mouth, Throat
		Hard of hearing
		Sinus headaches, hay fever
		Other ear, nose or throat problems.

Yes	No	Breathing & Respiratory Health
		Breathing problems / asthma
		COPD / Emphysema
		TB (Tuberculosis)

Yes	No	Heart/Vessels – Cardiovascular
		High blood pressure
		Stroke
		Heart problems (Explain):

Yes	No	General
		Recent unexplained weight loss/gain
		Tumor or cancer – Type:
		Hepatitis B / C

Yes	No	Stomach/Bowel – Gastrointestinal
		Stomach or intestinal problems
		Jaundice or liver disease

Yes	No	Genital/Urinary – Genitourinary
		Genital/urinary problems
		Kidney problems
		On medication for urine flow

Yes	No	Bone/Muscle – Musculoskeletal
		Arthritis, bone or joint problems

Yes	No	Skin/Tissue - Integumentary
		Dermatology problems
		Skin cancer

Yes	No	Nerve – Neurological
		Seizures
		Head injury
		Multiple Sclerosis

Yes	No	Endocrine
		Thyroid disease
		Diabetes: Do you use insulin? **Yes / No**
		Last A1C: Date taken:
		Fasting BGL: Type: **1 / 2**

Yes	No	Blood: Hematologic / Lymphatic
		Bleeding or blood clotting disorder
		Anemia
		High cholesterol
		Other:

Yes	No	Psychiatric
		Depression/anxiety
		Insomnia
		Mental illness

Yes	No	Allergic Immunologic
		Rheumatoid Arthritis
		HIV / AIDS
		Lupus / Sjogrens

Any other concerns the doctor should be made aware of?