Ophthalmology NJ, LLC

Medical History

Name: _____ PT#:_____ Date: _____

Date of Birth: _____

What is the reason for today's visit:

_____

_____

_____

_____

Date of Last eye exam: _____ Physician Name: _____

Do you currently wear: □ Glasses -□ Distance □ Reading □ Contact Lenses □ Neither

Past Eye History: (Please check if you have any of the following) Explain

- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Eye Surgery _____
- ☐ Retinal Detachments _____
- ☐ Other _____

Have you ever had an eye injury? □ Yes □ No _____

Please check any of the following problems you have with your **vision**

□ Blurred Vision □ Double Vision □ Floaters □ Flashes of light

□ Glare □ Halos around lights □ Poor Night Vision □ Distorted vision

□ Color Blindness □ Lazy Eye □ Other_____

Please check any of the following problems you have with your **eyes**

□ Red Eyes □ Dry Eyes □ Tearing □ Itching/Burning

□ Mucus in Eyes □ Foreign Body Sensation □ Sandy Sensation □ Sore to touch

□ Light Sensitivity □ Aching Pain □ Eyes turning in or out

Please check any of the following problems you have with your **eyelids**

□ Itching/Burning □ Dryness/Scaling □ Redness/Swelling □ Crusting

□ Granulation □ Other_____

MEDICAL HISTORY

Family Eye History: Relative

- ☐ Glaucoma _____
- ☐ Cataracts _____
- ☐ Eye Surgery _____
- ☐ Retinal Detachments _____
- ☐ Macular Degeneration _____
- ☐ Sjogren's Syndrome _____
- ☐ Other _____

Social History:

Current occupation_____

Do you drive? □ Yes □ No Any difficulty?_____

Do you drink alcohol? □ Yes □ No How much?_____

Do you smoke? □ Yes □ No How much?_____

Are you at risk of falling? □ Yes □ No If you have fallen this year, how many times? _____

Pharmacy:

Name:_____ Phone:_____

Address:_____ City: _____ State_____ Zip:_____

Primary Care Physician:

Name: _____ Phone:_____

Address: _____ City: _____State_____ Zip: _____

Please let us know if there is another physician you would like us to inform of your exam findings (for example, if you are a diabetic, we can update your endocrinologist).

Name: _____ Phone:_____

Address: _____ City: _____State_____ Zip: _____

Name: _____ Phone:_____

Address: _____ City: _____State_____ Zip: _____

MEDICAL HISTORY

Name: _____ Date: _____

If you have a history of any of the following, please check:

☐ Diabetes
☐ High Blood Pressure
☐ Heart Disorder
☐ Thyroid Disorder
☐ Bleeding Disorder
☐ Asthma
☐ Stroke
☐ Cancer
☐ Kidney Disease
□ Arthritis
☐ Other:
Explain: _____
_____
_____

Surgical History:

Surgery Date

_____

_____

_____

Medications:

Name Strength Frequency

_____

_____

_____

_____

_____

_____

_____

Allergies to Medications: Yes No

Please List: _____ _____ _____

_____ _____ _____

_____ _____ _____

Patient Signature: _____ Date: _____