CLEAR VIEW
• EYE CONSULTANTS •

Past Medical History: (please circle all that apply)

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Artificial joints	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Pacemaker
BPH	Hearing Loss	Prostate Cancer
Bone Marrow Transplantation	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	Hypercholesterolemia	Valve Replacement
	Hyperthyroidism	None

Other _____

Past Surgical History: (please circle all that apply) **L = Left R = Right**

Appendectomy	Hip Replacement L R	Pancreas Removed
Bladder Removed	Knee Replacement L R	Prostate Biopsy
Mastectomy L R	Kidney Biopsy L R	Prostate Removed: Prostate Cancer
Lumpectomy L R	Kidney Stone Removed	Prostate: TURP
Breast Biopsy L R	Kidney Transplant L R	Rectum Surgery
Colectomy: Resection	Kidney Removed L R	Skin Cancer Surgery
Colectomy: Diverticulitis	Liver Removed	Basal Cell Cancer Surgery
Colectomy: IBD	Liver Transplant	Melanoma Surgery
Gallbladder Removed	Liver Shunt	Squamous Cell Cancer Surgery
Heart Valve Surgery	Ovaries Removed: Cancer	Skin Biopsy
Heart Artery Bypass	Ovaries Removed: Cyst	Spleen Removed
Heart Angioplasty (Balloon)	Ovaries: Tubal Ligation	Testicles Removed
Heart/Coronary Artery Stent	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
Heart Transplant		

Other _____

Ocular History: (please circle all that apply) **L = Left Eye R = Right Eye**

Allergic conjunctivitis	L	R	Macular degeneration	L	R	Strabismus	L	R
Blepharitis	L	R	Macular ERM	L	R	"Crossed-Eyes"	L	R
Cataract	L	R	Narrow angles	L	R	"Lazy-Eye"	L	R
Cornea Transplant	L	R	Ocular hypertension	L	R			
Corneal dystrophy	L	R	Ophthalmic Migraine	L	R	Floaters	L	R
Diabetic retinopathy	L	R	Pseudoexfoliation	L	R	Vitreous Detachmt	L	R
Dry eyes	L	R				Retinal tear	L	R
Glaucoma	L	R	Yag capsulotomy	L	R	Retina Detachmt	L	R

Other _____

Ocular Surgery: (please circle all that apply) **L = Left Eye R = Right Eye**

	Year			Year			Year
Eye Surgery			Retina Injections	L	R	Laser	L R
Cataract surgery	L	R	Retina Laser	L	R	LASIK/PRK	L R
Cornea transplant	L	R				YAG Cap	L R
			Glaucoma Surgery				
Eye Lid Surgery	L	R	Trabeculectomy	L	R	YAG PI	L R
			Tube	L	R	SLT	L R
Eye Muscle Surgery	L	R	ExPress	L	R	ALT	L R
			iStent	L	R		L R
LASIK / PRK	L	R	ECP	L	R	Other	L R

Pharmacy:
Name: _____
Phone Number: _____
Address: _____

Primary Care Doctor:
Name: _____
Phone Number: _____
Address: _____

Medications: (Please list all current medications)

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Allergies: (Please list all allergies)

_____ _____ _____ _____
_____ _____ _____ _____

Social History: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: former smoker
- Smokes less than 1 pack per day
- Smokes daily

Alcohol:
- Do not drink at all
- Occasional drinks
- 1-2 drinks per day
- More than 3 drinks per day

Family History: (please circle all that apply) **M=Mother F=Father B=Brother S=Sister**

Blindness	M	F	B	S	Diabetes	M	F	B	S	Strabismus	M	F B S
Cancer	M	F	B	S	Glaucoma	M	F	B	S		M	F B S
Cataracts	M	F	B	S	Heart Disease	M	F	B	S		M	F B S
CVA	M	F	B	S	Migraine	M	F	B	S		M	F B S
Macular Degeneration	M	F	B	S						Retinal Detachment	M	F B S

Review of Systems: Are you currently experiencing any of the following? (please check YES or NO)

	System	YES	NO
Poor vision	Eyes		
Eye pain	Eyes		
Tearing	Eyes		
Redness	Eyes		
Jaw pain	Eyes		
Scalp tenderness	Eyes		
Amaurosis fugax	Eyes		
Loss of vision	Eyes		
Uncontrolled blood pressure	Cardiovascular		
Uncontrolled blood sugar	Endocrine		
Weight loss	Constitutional		
Stuffy nose	ENT		
Dry mouth	ENT		
Congestion	Respiratory		
Shortness of breath	Respiratory		
Upset stomach	Gastrointestinal		
Incontinence	Gastrointestinal		
Arthritis	Musculoskeletal		
Headache	Neurological		
Anxiety	Psychiatric		
Allergies	Allergic/Immunologic		

Other Symptoms: _____

Alerts: Are you currently experiencing any of the following? (please check YES or NO)

Alert	YES	NO
Allergy to adhesive		
Allergy to lidocaine		
Allergy to Fluorescein		
Allergy to Dilation Drops		
Blood thinners		
Defibrillator		
Flomax		
MRSA		
Narrow angles		
Pacemaker		
Premedication prior to procedures		
Rapid heart beat with epinephrine		
Pregnancy or planning a pregnancy		
Artificial joints within past two years		
Steroid responder--Eye Pressure		

Other Symptoms: _____