Eyecare Associates

HPI

Are you experiencing any of the following?

Loss or change of vision	No Yes
Blurry Vision	No Yes
Injury to affected eye	No Yes
Pain or irritation	No Yes
Problems around eye or lid	No Yes
Watery eyes	No Yes
Discharge	No Yes
Discoloration of eye	No Yes
Flashes or floaters	No Yes
Other	No Yes

Your Eye History

Do you have a history of any of the following?

Cataracts	No Yes
Glaucoma	No Yes
Retinal Detachment	No Yes
ANY Eye Surgery	No Yes
Iritis/Inflammation	No Yes
Corneal Disease	No Yes
Eye Injury	No Yes
Macular Degeneration	No Yes
Diabetic Retinopathy	No Yes
Dry Eyes	No Yes
Eye Pain	No Yes
Flashes or floaters	No Yes
Halos	No Yes
Allergies	No Yes
Glare sensitivity	No Yes
ANY FAMILY history of the above list?	No Yes
Do you wear glasses?	No Yes
Yes, how old are they?	_____
Do you wear contacts?	No Yes

Yes, type: **Soft or Daily Wear**, **Extended Wear** or **Gas Perm**

Please circle one of the following:

Living Situation: With Family, Alone, In a Facility

Working Situation: Full time, Part time, Retired, Students - circle one: Elementary, Middle/high school, College

Medical History

Diabetes	No Yes: Insulin/Non-insulin
High blood pressure	No Yes
Heart disease	No Yes
Heart attack	No Yes
Chest pains	No Yes
Irregular heart beat	No Yes
Pacemaker	No Yes
Cholesterol Issues	No Yes
Blood Clots	No Yes
Epilepsy/seizures	No Yes
Fainting	No Yes
Stroke/TIA	No Yes
Cancer	No Yes
HIV/AIDS	No Yes
Hepatitis	No Yes
Asthma	No Yes
Arthritis	No Yes
Lyme disease	No Yes
Gall bladder	No Yes
Sickle Cell anemia	No Yes
Ulcerative colitis	No Yes
Emotional problems	No Yes
Skin conditions	No Yes
Lupus	No Yes
Thyroid disease	No Yes
Parkinson	No Yes
MS	No Yes
Kidney disease	No Yes
Headaches	No Yes
Bronchitis	No Yes
Emphysema	No Yes
Pregnant/Nursing	No Yes
ANY FAMILY history of the above list?	No Yes

Height: **Weigh**t:

Social History

Do you drink alcohol? No Yes: Social or Daily
Do you smoke? No – Never smoked
Yes – every day or some days or
Former smoker

Advanced Directive

Do you have an Advanced Directive for Healthcare? No Yes

Patient Name:_____ **Date:**_____

Please list all of your medications below:

Medications

Eye Drops

Drug/Medication Allergies

Patient Name:_____

Date:_____