Rayner
EYE CLINIC

PATIENT INFORMATION AND MEDICAL HISTORY

Name _____ DOB_____ Date_____

1. I am here today because (please mark all that apply):
   A) A doctor at this or another clinic told me I have: ☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration ☐ Retinal Problem ☐ Dry Eyes ☐ Cornea Problem

   B) I need a checkup for: ☐ Cataracts ☐ Glaucoma ☐ Diabetes ☐ Macular Degeneration ☐ Decreased Vision ☐ Dry Eyes ☐ Previous Surgery ☐ Retinal Problem

   C) I am experiencing problems related to: ☐ Eye Pain ☐ Decreased Vision ☐ Dry Eyes ☐ Itchy/Scratchy Eyes ☐ Matted Eyes in Morning ☐ an Eye Injury - Work related? YES NO ☐ Flashing Lights ☐ Floaters ☐ Tearing/Redness ☐ Other _____

   D) ☐ I would like a Routine Eye Exam or Contact Exam
   ****PLEASE NOTE, IF YOU CHECK THIS BOX AND YOU HAVE MEDICARE, YOU WILL BE EXPECTED TO PAY IN FULL FOR TODAY'S VISIT.**

2. Approximately how long has it been since your last eye exam? _____

3. Who did that exam? _____

4. How long have you had your present glasses? _____

5. Do you currently wear contacts: YES NO

Please check the following vision problems you are experiencing.

_____ Hazy vision
_____ Blurry vision
_____ Difficulty reading newspapers
_____ Difficulty reading labels or price tags
_____ Difficulty reading a telephone book
_____ Difficulty sewing-threading a needle
_____ Do you use a magnifying glass to read?
_____ Difficulty seeing steps
_____ Difficulty seeing at a distance
_____ Difficulty watching television
_____ Vision more blurred in sunshine
_____ Difficulty driving in daytime
_____ Difficulty driving at night
_____ Difficulty seeing traffic signs
_____ Difficulty seeing traffic lights
_____ Difficulty recognizing people at a distance
_____ Difficulty seeing to hunt
_____ Difficulty doing a job or hobby because of blurred vision
_____ Seeing halos or streaks around lights
_____ Seeing multiple images

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I have reviewed with patient
HPI _____
PMH _____
PSH _____
Meds _____
FHx _____

Date _____
Initials _____

*** PLEASE TURN OVER AND ANSWER QUESTIONS ON BACK ***

Name _____ Date _____

Past Medical History:

Are you currently being treated for or have you in the past had problems with any of the following? If so please check.

_____ Eye Disease
_____ Headaches or Neurological disorders
_____ Ear Nose Throat problem
_____ Lung Disease
_____ Heart Disease
_____ Stomach Disease (GI)
_____ Kidney Problems
_____ Prostate Problems
_____ Arthritis or joint disease
_____ Nervous (Psychiatric) disorders
_____ High Blood Pressure
_____ Diabetes
_____ Skin Diseases
_____ Blood Disease
_____ Fever or Weight Loss
_____ Thyroid Problems

If yes, please explain _____

Surgeries:

List any Eye surgery OR OTHER SURGERY you have had. _____

Medications:

Please list all medications you are taking. _____

Allergies:

Are you allergic to any medications? _____ yes _____ no

If so what kind _____

Family History:

Has anyone in your family ever had any of the following?

glaucoma _____ cataract _____ blindness _____ other eye disease _____

diabetes _____

List any disease that runs in your family _____

Social History:

Do you smoke? _____ Did you ever smoke? _____

Do you consume more than one or two alcoholic beverages per day?

_____ yes _____ no

Do you live alone? _____ yes _____ no