

PERSONAL HISTORY (ROS) - Do you currently have any of the following problems?

System	Yes or No	Date diagnosed	Please describe
Eye disease, eye injury, eye surgery	<input type="checkbox"/> Y <input type="checkbox"/> N		
Constitutional (fever, weight loss, other)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Ears (reduced hearing or hearing loss)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Nose/Mouth/Throat (sinus problems, sore throat)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cardiovascular (heart, blood vessels), hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N		
Respiratory (breathing problems, lungs, cough)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Neurological (numbness, weakness, stroke, headaches, paralysis,)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Females – Pregnant? / Nursing?	<input type="checkbox"/> Y <input type="checkbox"/> N		
Genitourinary (reproductive organ problems, urinary problems, kidneys)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Cancer (List Type)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Dermatologic (skin)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Musculoskeletal (muscle or joint problems)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Rheumatological (Rheumatoid Arthritis, Lupus, Sarcoidosis, gout, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N		
Allergic/Immunologic	<input type="checkbox"/> Y <input type="checkbox"/> N		
Psychiatric (depression)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Hematologic (bleeding tendency, anemia)	<input type="checkbox"/> Y <input type="checkbox"/> N		
Any other health issues	<input type="checkbox"/> Y <input type="checkbox"/> N		
Do you Use tobacco, alcohol or drugs?	<input type="checkbox"/> Y <input type="checkbox"/> N		

Please list all medications you take (we will copy your prepared list if you wish)

Name of Medication	Taken for what condition	Dosage	Frequency	Name of Medication	Taken for what condition	Dosage	Frequency

Please list all major illnesses or surgeries you have had (we will copy your prepared list if you wish)

Procedure / Diagnosis	Reason	Date

Family History

- Amblyopia (Lazy Eye)
- Glaucoma Diabetes Macular Degeneration
- Cataracts Heart Disease Retinal Detachment
- Stroke Hypertension Strabismus (Eye turn)

Please list who has these problems: _____

Visual Function

- Are you satisfied with your current vision? Y N
- Do you wear glasses? Y N
- Do you wear computer glasses? Y N
- Do you wear prescription sunglasses? Y N
- Do you wear non-prescription sunglasses? Y N
- Do you wear safety or sport goggles? Y N
- Do you wear contact lenses? Y N
- What solutions do you use? _____
- What brand or type of lenses do you wear? _____
- Are you interested in laser vision correction? Y N

Are you experiencing any difficulty with the following?

- Reading small print Y N
- Reading a newspaper or book Y N
- Working on the computer Y N
- Recognizing people when close Y N
- Seeing steps, stairs, or curbs Y N
- Bothered by glare/halos Y N
- Difficulty driving on bright sunny days Y N
- Difficulty driving at night Y N
- Reading traffic signs, street signs Y N
- Doing fine handiwork Y N
- Writing checks, completing forms Y N
- Playing games (i.e. bingo, cards) Y N
- Participating in sports Y N
- Cooking/Hobbies Y N
- Watching TV Y N