



Kennedy

Vision Health Center

Preferred Name _____ **Sex:** M F **Age:** _____ **Date:** ____/____/____

Date of Last Medical Exam: ____/____/____ Primary Physician/Clinic: _____

Date of Last Eye Exam: ____/____/____ Clinic/Eye Doctor's Name: _____

Employer/School: _____ Occupation/School Grade: _____

Sports/Hobbies: _____ Number of Children? _____ Ages: _____

PLEASE CIRCLE ANY OF THE FOLLOWING PAST OR PRESENT CONDITIONS THAT APPLY TO YOU:

- | | | | |
|---------------------------|--------------|-------------------|--------------------|
| Blurred Vision - Distance | Burning Eyes | Floaters or Spots | Headaches |
| Blurred Vision - Near | Itchy Eyes | See Flashes | Migraine Headaches |
| Double Vision | Dry Eyes | See Halos | Loss of Vision |
| Eye Strain | Red Eyes | Poor Night Vision | Crossed Eyes |
| Eye Infections | Watery Eyes | Poor Color Vision | Light Sensitive |

NOTES: _____

My problem today is: _____

This started on (approximate date): _____

It started where (work, home, etc.): _____

It started how (accident, sporting event, etc): _____

Do you wear glasses? Yes No For What? _____

Do you wear contacts? Yes No Type: _____ Replacement Schedule: _____

Have you had LASIK? Yes No Are you interested in LASIK refractive surgery? Yes No

Are you pregnant? Yes No How far along? _____

Have you ever had any eye injuries? Yes No Which eye? _____

Have you ever had any eye surgeries? Yes No Why? _____

Have you ever taken eye medication? Yes No Why? _____

Have you ever been diagnosed with? Cataracts: Yes No Diagnosed when? _____

Glaucoma: Yes No Diagnosed when? _____

Macular Degeneration: Yes No Diagnosed when? _____

Personal Medical History (Review of Systems): Please check if any of the following **APPLIES to you**, and list any medications for each condition that you check. **If you have none of these conditions, please check None.**

Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> Hypertension <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Medications: _____	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Non-insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____
Neurological <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Medications: _____	Immunologic <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Medications: _____
Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Development Disability <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Genitourinary: <input type="checkbox"/> None <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infections <input type="checkbox"/> STD - HIV, Herpes, Chlamydia <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> Nervousness/Panic Disorder <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Medications: _____
Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Chrohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____
Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: <input type="checkbox"/> Medications: _____	Allergies (Please List) <input type="checkbox"/> None Drug: Environmental: <input type="checkbox"/> None	Alcohol Use: Y N Amount:
		Tobacco Use: Y N Amount:

Please list any medications (including Herbal, and Vitamins) and/or drugs that you are taking that were not listed above: _____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with?

Blindness:	Y	N	Who? _____
Cataracts:	Y	N	Who? _____
Glaucoma:	Y	N	Who? _____
Crossed Eyes:	Y	N	Who? _____
Macular Degeneration:	Y	N	Who? _____
Retinal Detachment:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
Thyroid Disease	Y	N	Who? _____
Heart Disease:	Y	N	Who? _____
Cancer:	Y	N	Who? _____

Reviewed By

Doctor:	Date:	Patient:	Date: