Welcome to Cabot Family Eye Care

Date of Birth: ___/___/_____ Today's Date: ____/____/_____

Last Name: ________________________________ First Name: __________________________ MI: _________

Last Eye Exam: ____/____/____ Dr: _________________________ Clinic: ________________________

Medical History

Do you have any allergies to medications? No: ____ Yes: ___ If Yes please List: __________________________________

____

List any medications you take:

____

Are you pregnant and/or nursing? No: ___ Yes: ___

Do you wear glasses? No: ___ Yes: ___ If Yes, how old are they? ____________

Do you wear contact lenses? No: ___ Yes: ___ If Yes, how old are they? ____________

Past, Family and Social History

Please check if any of you or a family members have any of the following:

Condition	Self	Family	Condition	Self	Family
Blindness:	Self: ____	Family: ____	Cancer:	Self: ____	Family: ____
Cataract:	Self: ____	Family: ____	Diabetes:	Self: ____	Family: ____
Glaucoma:	Self: ____	Family: ____	High Blood Pressure:	Self: ____	Family: ____
Macular Degeneration:	Self: ____	Family: ____	Kidney Disease:	Self: ____	Family: ____

Do you use tobacco products? No: ____ Yes: ____

Do you drink alcohol? No: ____ Yes: ____

Review of Systems

Do you currently, or have you ever had any problems with any of the following:

Constitutional

	No	Yes
Fever	No: ____	Yes: ____
Weight Loss	No: ____	Yes: ____
Developmental Disability	No: ____	Yes: ____
Genetic Disorder	No: ____	Yes: ____

Other ____________________

Neurological

	No	Yes
Headaches	No: ____	Yes: ____
Migraines	No: ____	Yes: ____
Seizures/Epilepsy	No: ____	Yes: ____
Alzheimers	No: ____	Yes: ____
Multiple Sclerosis	No: ____	Yes: ____

Other _____________________

Eyes

	No	Yes
Loss of Vision:	No: ____	Yes: ____
Blurred Vision:	No: ____	Yes: ____
Distorted Vision:	No: ____	Yes: ____
Loss of Side Vision:	No: ____	Yes: ____
Double Vision:	No: ____	Yes: ____
Dryness	No: ____	Yes: ____
Mucous Discharge:	No: ____	Yes: ____
Redness:	No: ____	Yes: ____
Sandy or Gritty Feeling:	No: ____	Yes: ____
Itching:	No: ____	Yes: ____
Burning:	No: ____	Yes: ____
Foreign Body Sensation:	No: ____	Yes: ____
Excess Tearing/Watering:	No: ____	Yes: ____
Glare/Light Sensitivity:	No: ____	Yes: ____
Eye Pain/Soreness:	No: ____	Yes: ____
Flashes/Floaters:	No: ____	Yes: ____

Endocrine

	No	Yes
Thyroid/Other Glands:	No: ____	Yes: ____
Non-Insluin Diabetes	No: ____	Yes: ____
Insluin Diabetes	No: ____	Yes: ____

Other _____________________

Ear, Nose, Mouth, Throat

	No	Yes
Allergies/Hay Fever	No: ____	Yes: ____
Sinus Congestion	No: ____	Yes: ____
Post-Nasal Drip	No: ____	Yes: ____
Chronic Cough	No: ____	Yes: ____

Other _____________________

Respiratory

	No	Yes
Asthma	No: ____	Yes: ____
Emphysema	No: ____	Yes: ____

Vascular/Cardiovascular

	No	Yes
Vascular Disease	No: ____	Yes: ____
Heart Disease	No: ____	Yes: ____
High Blood Pressure	No: ____	Yes: ____
Stroke	No: ____	Yes: ____

Other _____________________

Gastrointestinal

	No	Yes
Digestive Problems	No: ____	Yes: ____
Colitis	No: ____	Yes: ____
Crohn's	No: ____	Yes: ____

Other _____________________

Genitourinary

	No	Yes
Kidney Disease/Bladder	No: ____	Yes: ____

Bones/Joints/Muscles

	No	Yes
Osteoarthritis/General arthritis	No: ____	Yes: ____
Muscle Pain	No: ____	Yes: ____

Lymphatic/Hematologic

	No	Yes
Anemia	No: ____	Yes: ____
Bleeding Problems	No: ____	Yes: ____

Immunologic

	No	Yes
Rheumatoid Arthritis	No: ____	Yes: ____
Lupus	No: ____	Yes: ____

Psychiatric

	No	Yes
Depression	No: ____	Yes: ____
Anxiety	No: ____	Yes: ____

Other _____________________