D D Loewit & Associates
Optometrist

Name: ____ Date: _____________

Date of Birth: __________________________

List any medications you currently take (prescription and over-the-counter): __________________________________
____
____

Do you have allergies to any medications? ❑ Yes ❑ No
If YES, list the medications:
____

Please circle if you have had the following: chicken pox, hernia, measles, polio, venereal disease, hemorrhoids, liver disease, mumps, rheumatic fever, hepatitis, malaria, pancreatitis

List any surgeries you have had (cataract, tonsillectomy, appendectomy):
____
____

Do you currently have any problems in the following areas? If "YES", please provide information:

	YES	**NO**	**Explanation of Problem**
EYES (glaucoma, cataract, retinal disease, etc.)			
Loss of vision			
Blurred vision			
Fluctuating vision			
Distorted vision			
Double vision			
Dryness			
Mucous discharge			
Redness			
Sandy or gritty feeling			
Itching			
Burning			
Foreign body sensation			
Excess tearing/watering			
Glare/light sensitivity			
Eye pain or soreness			
Infection of eye or lid (blepharitis, stye)			
Tired eyes			
Crossed eyes, lazy eye			
Drooping eyelid			
GENERAL/CONSTITUTIONAL			
Fever			
Weight Loss			
Other			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			

OVER

	YES	NO	Explanation of Problem
CARDIOVASCULAR (Heart, blood pressure, stroke)			
RESPIRATORY (Asthma, emphysema, bronchitis)			
GASTROINTESTINAL (stomach ulcers, intestinal disease, etc)			
GENITAL, KIDNEY, BLADDER			
MUSCLES, BONES, JOINTS (Arthritis, etc)			
SKIN (Dermatitis, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, headaches)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
ENDOCRINE (Diabetes, thyroid, etc.)			
BLOOD/LYMPH (Cancer, high cholesterol, anemia)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogrens, etc.)			

FAMILY HISTORY M=mother F=father S=sibling GP=grandparent

DISEASE	YES	NO	RELATIONSHIP TO PATIENT
Blindness			
Glaucoma			
Arthritis			
Cancer			
Diabetes			
Heart disease or high blood pressure			
Kidney disease			
Lupus			
Stroke			
Thyroid disease			
Other			

SOCIAL HISTORY

Current occupation:______________________________

Education (high school, vocational school, college degree):______________________________

Marital Status (married, divorced, single, widowed):______________________________

Do you drive? __ YES __ NO

Do you have visual difficulty when driving? __ YES __ NO

Do you have problems with night vision? __ YES __ NO

Have you ever tried to wear contact lenses? __ YES __ NO

Do you currently wear contact lenses? __ YES __ NO

If YES, How long have you worn contact lenses? ______________________________

Do you currently wear glasses? __ YES __ NO

If YES, how long have you had the current prescription? ______________________________

Do you drink Alcohol? __ YES __ NO If YES: occasional 1/day 2-3/day 4+/day

Do you smoke? __ YES __ NO If YES: occasional 1pack/day 2-3 pack/day 4+ packs/day

Have you ever had a blood transfusion? __ YES __ NO

Patients/ Signature: ______________________________ Date: ____________

Internal use only:

Physician's Signature: ______________________________ Date: ____________