Today's Date_____

Shore Eye Associates

Chart No. _____

Name _____ Date of Birth _____ Social Security #_____-_____-_____

Address_____ City_____ ST _____ ZIP _____

Phone (Home)_____ (Cell)_____ Email_____

Sex: M F Marital Status _____ Occupation _____

Medical Doctor _____ Date of last visit _____ Who referred you_____

***Race***: White __ Asian __ Black /African American __ Hawaiian/Pacific Islander __ American Indian/Alaska Native __

***Ethnicity***: Hispanic or Latino __ Not Hispanic or Latino __ ***Language Preference*** _____

If you are not the primary insurance holder, please fill out below:

Name of Policy Holder_____ Date of Birth _____ Social Security#_____

## OCULAR AND MEDICAL HISTORY

Reason for visit:_____

Do you wear : Glasses_____ Contacts ____ Last Eye Exam: Date_____ Dr. _____

**Eye Symptoms** (Please check any problems you currently have):

____ Blurred vision
____ Trouble with colors
____ Double vision
____Poor night vision
____Glare from lights
____Halos around lights
____Spots or floaters
____Flashing lights
____Gritty sensation
____Tearing
____Itching or burning
____Redness

**Eye and Medical Conditions** (Please mark any condition that you or a blood relative have ever had):

| You | Relative | | You | Relative | | You | Relative | |
|---|---|---|---|---|---|---|---|---|
| ___ | ___ | Dry Eyes | ___ | ___ | Hypertension | ___ | ___ | Heart disease |
| ___ | ___ | Macular degeneration | ___ | ___ | Diabetes | ___ | ___ | Lung disease(asthma, COPD) |
| ___ | ___ | Glaucoma | ___ | ___ | Stroke | ___ | ___ | Thyroid disease |
| ___ | ___ | Retinal Detachment | ___ | ___ | Arthritis | ___ | ___ | Migraines |
| ___ | ___ | Cataracts | ___ | ___ | Ulcers | ___ | ___ | Other _____ |

**REVIEW of SYSTEMS** (Please check all that apply)

***Constitutional***
□ Fever
□ Weight loss

***Dermatologic***
□ Rash
□ Rosacea

***Ears/Nose/Throat***
□ Sinus problems
□ Dry mouth
□ Hearing loss

***Respiratory***
□ Cough
□ Shortness of Breath

***Cardiac***
□ Chest pain
□ Irregular heart beat

***Gastrointestinal***
□ Bloody stools
□ Diarrhea

***Genitourinary***
□ Kidney stones
□ Pain with urination
□ Blood in urine
□ Genital ulcer

***Neurologic***
□ Headaches
□ Tingling/numbness
□ Difficulty with speech
□ Multiple sclerosis

***Musculoskeletal***
□ Joint pain
□ Back pain

***Allergy/Immunologic***
□ Seasonal allergies
□ Lupus

***Hematologic***
□ Abnormal bleeding
□ Abnormal bruising

Have you ever had Cancer? No/Yes- list_____

Have you ever had eye surgery? No/Yes - list including dates_____

Have you ever had any previous surgeries? No/Yes - list_____

Do you smoke? _____Yes _____No _____Former smoker (smoked ___ pack per day for ____ years, quit ___ years ago)

Medications (including eye drops)_____

_____

Allergies (especially medications): ___None or List_____

**PLEASE MAKE SURE ALL SECTIONS ARE COMPLETED**