KOZIOL-THOMS EYE ASSOCIATES

Patient Name:_____

Current Eye Symptoms - *Are you currently experiencing any of the following?*

❑ Double vision ❑ Flashes or floaters ❑ Dryness/Irritation ❑ Itching
❑ Lid bump(s) ❑ Pain ❑ Something in the Eye ❑ Tearing
❑ Vision Change/Loss ❑ Other:_____

Current Eye Problems - *Do you currently have or been diagnosed with:*

❑ Cataract ❑ Diabetic Eye Problems ❑ Dry Eye ❑ Glaucoma
❑ Macular Degeneration ❑ Retinal Problems ❑ Other:_____

History of Eye Surgery - *Have you ever had the following?*

❑ Glaucoma Surgery ❑ Cataract Surgery ❑ Injections ❑ Laser Surgery
❑ Lasik Surgery ❑ Retinal Surgery ❑ Other:_____

Current Conditions - *Do you currently have or been diagnosed with:*

General
❑ Fever
❑ Fatigue
❑ Other:_____

Ear, Nose, Throat
❑ Hearing Loss
❑ Sinus Problems
❑ Other:_____

Cardiovascular
❑ Atrial Fibrillation
❑ Heart Disease
❑ Hypertension
❑ Stroke
❑ Other:_____

Respiratory
❑ Asthmas
❑ Emphysema
❑ Shortness of Breath
❑ Other:_____

Gastrointestinal
❑ Intestinal Problems
❑ Other:_____

Urinary
❑ Kidney Disease
❑ Urinary Symptoms
❑ Other:_____

Musculoskeletal
❑ Arthritis
❑ Muscle/Joint/Back Pain
❑ Other:_____

Skin
❑ Herpes
❑ Rash/Itching
❑ Rosacea
❑ Shingles
❑ Skin Cancer
❑ Other:_____

Neurological
❑ Migraine
❑ Multiple Sclerosis
❑ Seizures
❑ Other:_____

Psychiatric
❑ Memory Loss
❑ Depressions
❑ Other:_____

Endocrine
❑ Diabetes
❑ Thyroid Disease
❑ Other:_____

Blood
❑ Anemia
❑ Cholesterol
❑ Other:_____

Allergic/Immunologic
❑ Seasonal Allergies
❑ Lupus
❑ Other:_____

❑ Pregnant
❑ Nursing
❑ Other:_____

Social History - *Do you currently:*

❑ Drink Alcohol ❑ Current Smoker ❑ Past Smoker ❑ Exercise
How much:_____ How much:_____ Quit When:_____ How Often:_____

What is your current occupation:_____

Medication Allergies:_____

Current Medications - *(Name, Strength, How Often)*

_____
_____
_____
_____

Family History of Eye Problems - *Has any BLOOD RELATIVE had the following?*

❑ Amblyopia (Lazy Eye) ❑ Blindness ❑ Cataracts ❑ Color Blindness
❑ Glaucoma ❑ Macular Degeneration ❑ Retinal Detachment ❑ Strabismus
❑ Other:_____

Family History of Disease - *Has any BLOOD RELATIVE had the following?*

❑ Arthritis ❑ Diabetes ❑ Cancer ❑ Heart Disease
❑ High Blood Pressure ❑ Kidney Disease ❑ Lupus ❑ Stroke
❑ Thyroid Disease ❑ Other:_____

Patient Signature:_____ Date:_____