RIDDLE EYE
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Ophthalmic Medical and History Form

Patient name: _____Date:_____

Date of Birth: _____Family Physician: _____/fax_____

Email: _____ Pharmacy: _____/ph_____

Please circle items that best describe the reason for your visit today:

routine eye exam (glasses/contact lenses) new problem or follow up for a medical condition

loss of vision	eye pain	dry eyes
loss of side vision	tearing	sandy/ gritty feeling
double vision	itching	foreign body feeling
blurred vision	redness	tired eyes
fluctuating vision	mucous discharge	glare/ halos
distorted vision	light sensitivity	headaches
flashes/ floaters	swelling of eyelid	other:_____

Past Medical History: (Please list any major illnesses that you have had in the past or for which you are currently under the care of a physician):_____

_____
_____
_____
_____
_____

Past Surgical History: (Please list any surgeries that you have had in your lifetime)

_____
_____

Family History: (Please circle)

Blindness	Cancer	Cataracts	Retinal Detachment
Migraine	Diabetes	Glaucoma	"Lazy eye"(amblyopia)
Heart Disease	Hypertension	Macular Degeneration	Other:_____

Ocular History: (Please list any eye disease , eye trauma, ocular surgery, or laser procedure you have had)

_____
_____
_____**Do you wear contact lenses**? Yes/No Brand_____

Parameters, if known_____

Ocular medications: (Please list any eye drops that you currently use. Include over the counter drops.)

_____
_____

Systemic Medications: (Please list all medications that you use. Include over the counter medications/ supplements as well as any topical (skin) preparations.) _____

_____
_____

Allergies: (Please list any known drug or environmental allergies.)_____

_____

Smoking status: Current smoker Past smoker Never smoked

Pregnant or breast feeding? Yes No

Do you drive? No Yes (If yes, circle: nighttime/ daytime/ both)

Occupation: _____

Review of Systems: (Circle any of the following that apply to your current medical status)

Cardiovascular:	high blood pressure	heart attack	pace maker/defibrillator	Other
Endocrine:	diabetes	thyroid disease		Other
Musculoskeletal:		arthritis	muscle pain	Other
Neurological:	headache	stroke/paralysis	seizure	Other
Psychiatric:	depression	Anxiety	hallucinations	Other
Respiratory:	shortness of breath	cough	bronchitis	Other
Skin:	rosacea	rash	bruising	Other
Genitourinary:	urinary frequency	burning with urination	blood in urine	Other
ENT:	dry mouth	congestion	sinus pressure	Other
Gastrointestinal:	nausea	diarrhea	constipation	Other