HARKINS EYE CLINIC Name_____

Have you ever been diagnosed with the following medical conditions and/or currently being treated for: Please circle all that apply.

Cataracts
Macular Degeneration
Glaucoma
Lazy Eye
Droopy Eyelids
Diabetes
Dry Eye
Eyelid Inflammation
High cholesterol
Congestive Heart Failure
Migraine w/w/o visual disturbance
Hepatitis A, B, or C
Methicillin Resistant Staph Aureus (MRSA)
Arthritis (Rheumatoid or degenerative)
Heart Disease
Stroke
Osteoporosis
Sleep Apnea
Emphysema
Hypertension
Diverticulitis
Heart Attack
Depression
Tuberculosis
Dementia
Thyroid Disease
Hearing Loss
Cancer
COPD
Obesity
Acid Reflux (GERD)
Atrial Fibrillation
Anxiety
Coronary Artery Disease
Asthma
Kidney Disease
Liver Disease
HIV/AIDS

Review of Systems: Please **CIRCLE** all that apply:

Chest Pain
Irregular Heartbeat
Shortness of Breath
Dizziness
Hearing loss / ringing in ears
Headaches
Balance problems
Numbness / Tingling
Fatigue
Paralysis
Back / Joint pain / Swollen joints
Weight loss / gain
Bruising
Rash / excessive dryness
Depression
Insomnia
Irritability
Chronic runny nose
Frequent / Painful urination
Skin lesions
Fever
Weakness
Blood in urine
Diarrhea
Vomiting
Nervousness
Hives / Itching
Abdominal pain

PAST SURGICAL / LASER PROCEDURES (EYE)

PLEASE CHECK ALL THAT APPLY WITH APPROXIMATE DATE OF PROCEDURE & BY WHOM.

Cataract Surgery _____ Laser (type) _____

Glaucoma Surgery_____ Muscle surgery _____

Retinal Detachment_____ Retinal Tear _____

LASIK / PRK _____ RK _____

Eye Injections (# of injections & dates) _____

CONTINUED ON BACK

PAST SURGICAL PROCEDURES (NON-EYE related) Please list any major surgeries (joint replacement, heart, etc.) you may have had with approximate date.

_____

_____.

FAMILY HISTORY : **Please Circle any of the conditions that may apply in your family.**

Glaucoma **Diabetes** **Heart Dz.** **Stroke** **Corneal Dz.** **Thyroid Dz.**

Macular Degeneration **Retinal Tear / Detachment** **Cataracts** **Lazy Eye**

ALLERGIES : **(With reaction, if known)** _____

_____.

Please give a current list of medications with dosing and milligrams to the front office to copy or please list.

_____

_____.

SOCIAL HISTORY (PLEASE CIRCLE ALL THAT APPLY)

Smoke **Alcohol** **Recreational Drugs** **None**

Do you wear contact lenses? If so what type, brand, power, and base curve (BC). Please list.

_____

I have read all the information on this form and have completed all the blanks. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

PATIENT SIGNATURE _____ **DATE** _____

PARENT (if minor) _____ **DATE** _____

CONTINUED ON BACK