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EYE TO EYE CLINIC

PROFESSIONAL FAMILY EYE CARE • CONTACT LENSES
REFRACTIVE SURGERY CONSULTATION • EYE DISEASE MANAGEMENT
DR. ROSILAND HURSH • DR. LORNE YUDCOVITCH
OPTOMETRIC PHYSICIANS

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(503) 682-8696 (fax)

Last Name_____First Name_____Middle Initial ____
Address _____City _____State___Zip _____
Telephone (H) _____ (W) _____ (Mobile) _____
Date of Birth_____ Height_____ Weight_____E-Mail: _____
Occupation _____Marital Status *(circle one)* S M D W
Employer _____
Emergency Contact/Telephone Number _____
Last Eye Exam Date/Location _____Dilated? ___Today's Date _____
Whom may we thank for referring you? _____

Medical Information/Review of Systems

List any **medications** you take (prescription and over-the-counter):

_____

_____

Do you have **allergies** to any medications? ☐ Yes ☐ No
If YES, list the medication(s):

_____

_____

List all **major illnesses** (glaucoma, diabetes, high blood pressure, heart attack, etc.) or injuries (concussion, etc.):

_____

_____

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			
Flashes/Floaters in vision			
Distorted vision/halos			
Loss of side 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			
Tired eyes			
Crossed eyes, lazy eye			

	YES	NO	Explanation of Problem
GENERAL/CONSTITUTIONAL (Fever, weight loss/gain, other)			
EARS, NOSE, THROAT (Sinus, ear infection, chronic cough, dry mouth, etc.)			
ENDOCRINE (Diabetes, thyroid, other)			
CARDIOVASCULAR (High blood pressure, heart disease, stroke, vessel disease, etc.)			
RESPIRATORY (Asthma, emphysema, etc.)			
GASTROINTESTINAL (Stomach ulcers, intestinal disease, etc.)			
GENITAL, KIDNEY, BLADDER			
SKIN (Acne, warts, skin cancer, etc.)			
NEUROLOGICAL (Multiple sclerosis, headaches, migraines, seizures, etc.)			
PSYCHIATRIC (Anxiety, depression, insomnia)			
MUSCLES, BONES, JOINTS (Arthritis, etc.)			
BLOOD/LYMPH (cholesteremia, anemia, etc.)			
ALLERGIC/IMMUNOLOGIC (Hay fever, lupus, Sjogren's etc.)			

Family History M = Mother F = Father S = Sibling GP = Grandparent

DISEASE	YES	NO	Relationship to Patient
Blindness			
Glaucoma			
Macular degeneration			
Retinal detachment/disease			
Crossed eyes, lazy eye			
Diabetes			
High blood pressure			
Arthritis			
Lupus			
Kidney disease			
Thyroid disease			
Cancer			
Stroke			
Other			

Social History

Do you drive? ☐ Yes ☐ No
Do you have difficulty when driving? ☐ Yes ☐ No
Do you have problems with night vision? ☐ Yes ☐ No
Do you use an illegal drug? ☐ Yes ☐ No If YES: Type/Amount _____
Do you drink alcohol? ☐ Yes ☐ No If YES: occasional 1 per day 2-3/day 4+/day
Do you smoke? ☐ Yes ☐ No ☐ Past If YES: occasional ½ pack/day 1 pack/day 1+ pack/day
Have you ever had a blood transfusion? ☐ Yes ☐ No

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

History reviewed. Additions as noted above