SOUTHERN KENTUCKY EYE CENTER

TODAY'S DATE: ___/____/_____

PATIENT NAME:_____ DOB: ___/___/_____

PRIMARY CARE PHYSICIAN: _____

OPTOMETRIST: _____

CARDIOLOGIST: _____

PRESENTING PROBLEM (BRIEF EXPLANATIN FOR THE REASON FOR TODAY'S VISIT)
_____ _____ _____
ARE THERE ANY ACTIVITIES THAT WORSEN THE PROBLEM? (READING, DRIVING LIGHT, ETC…)
ARE THERE ANY PROBLEMS ASSOCIATED WITH THE PROBLEM? (GLARE, LIGHT SENSITIVITY, ETC…)
HOW LONG HAVE YOU HAD THIS PROBLEM? _____DAYS _____WEEKS _____MONTHS _____YEARS
WHICH EYE IS AFFECTED? _____RIGHT _____LEFT _____BOTH
IS THE PROBLEM _____CONSTANT _____OCCASIONALLY _____JUST ONCE
PLEASE RATE THE SEVERITY OF THE PROBLEM ___MILD ___MINIMAL ___SIGNIFICANT ___ MODERATE __ SEVERE
ALLERGIES:

PAST OCCULAR (EYE) HISTORY (MARK ALL THAT APPLY)

☐**OVERALL HEALTHY** ☐CATARACTS ☐HYPEROPIA (FAR SIGHTED) ☐MYOPIA (NEAR SIGHTED)
☐AMBLYOPIA (LAZY EYE) ☐DIABETIC RETINOPATHY ☐IRITIS ☐OPTIC NEURITIS
☐APHAKIA ☐DRY EYES ☐KERATOCONUS ☐RETINAL DETACHMENT
☐ASTIGMATISM ☐GLAUCOMA ☐MACULAR DEGENERATION ☐TRAUMA
OTHER_____

PAST OCCULAR (EYE) SURGERIES (MARK ALL THAT APPLY)

☐**NO PRIOR OCCULAR SURGERIES**
☐FOREIGN BODY REMOVAL ☐PUNCTAL PLUGS ☐TRABECULECTOMY (GLAUCOMA SURGERY)
☐BLEPHAROPLASTY ☐RETINAL LASER SURGERY ☐RK ☐VITRECTOMY
☐CATARACT SURGERY
☐CORNEAL TRANSPLANT ☐STRABISMUS/ MUSCLE SURGERY
☐LASIK ☐PRK
OTHER:_____

PAST MEDICAL HISTORY (MARK ALL THAT APPLY) IF NO PAST MEDICAL HISTORY PLEASE CHECK BOX ☐

☐DIABETIC	☐HIGH BLOOD PRESSURE	☐HIGH CHOLESTEROL	☐HYPERTHYROIDISM	☐GOITER
☐PSORIASIS	☐ANGINA	☐HEART PROBLEMS	☐HEART MURMER	☐PNEUMONIA
☐PULMONARY EMBOLISM	☐ASTHMA	☐EMPHYSEMA	☐STOKE	☐EPLIPSY (SEIZURES)
☐CATARACTS	☐KIDNEY DISEASE	☐KIDNEY STONES	☐CHROHN'S DISEASE	☐ANEMIA
☐JAUNDAICE	☐HEPATITIS	☐HIV/AIDS	☐TUBERCULOSIS	
☐CANCER (TYPE)		☐LUKEMIA		

☐**OTHER PAST MEDICAL**_____

PAST MEDICAL SURGERIES: ☐ **NO PAST MEDICAL SURGERIES** ☐
