PERSONAL HISTORY (ROS) - Do you currently have any of the following problems?

System	Yes or No	Date diagnosed	Please describe
Eye disease, eye injury, eye surgery	☐ Y ☐ N		
Constitutional (fever, weight loss, other)	☐ Y ☐ N		
Ears (reduced hearing or hearing loss)	☐ Y ☐ N		
Nose/Mouth/Throat (sinus problems, sore throat)	☐ Y ☐ N		
Cardiovascular (heart, blood vessels), hypertension	☐ Y ☐ N		
Respiratory (breathing problems, lungs, cough)	☐ Y ☐ N		
Gastrointestinal (heartburn, diarrhea, vomiting, GERD, acid reflux)	☐ Y ☐ N		
Neurological (numbness, weakness, stroke, headaches, paralysis,)	☐ Y ☐ N		
Females – Pregnant? / Nursing?	☐ Y ☐ N		
Genitourinary (reproductive organ problems, urinary problems, kidneys)	☐ Y ☐ N		
Cancer (List Type)	☐ Y ☐ N		
Dermatologic (skin)	☐ Y ☐ N		
Musculoskeletal (muscle or joint problems)	☐ Y ☐ N		
Rheumatological (Rheumatoid Arthritis, Lupus, Sarcoidosis, gout, etc.)	☐ Y ☐ N		
Diabetes	☐ Y ☐ N		
Allergic/Immunologic	☐ Y ☐ N		
Psychiatric (depression)	☐ Y ☐ N		
Hematologic (bleeding tendency, anemia)	☐ Y ☐ N		
Any other health issues	☐ Y ☐ N		
Do you Use tobacco, alcohol or drugs?	☐ Y ☐ N		

Please list all medications you take (we will copy your prepared list if you wish)

Name of Medication	Taken for what condition	Dosage	Frequency	Name of Medication	Taken for what condition	Dosage	Frequency

Please list all major illnesses or surgeries you have had (we will copy your prepared list if you wish)

Procedure / Diagnosis	Reason	Date

Family History

- ☐ Glaucoma
- ☐ Diabetes
- ☐ Amblyopia (Lazy Eye)
- ☐ Cataracts
- ☐ Heart Disease
- ☐ Macular Degeneration
- ☐ Stroke
- ☐ Hypertension
- ☐ Retinal Detachment
- ☐ Strabismus (Eye turn)

Please list who has these problems: ____________________

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Visual Function

Question	Y/N
Are you satisfied with your current vision?	☐ Y ☐ N
Do you wear glasses?	☐ Y ☐ N
Do you wear computer glasses?	☐ Y ☐ N
Do you wear prescription sunglasses?	☐ Y ☐ N
Do you wear non-prescription sunglasses?	☐ Y ☐ N
Do you wear safety or sport goggles?	☐ Y ☐ N
Do you wear contact lenses?	☐ Y ☐ N

What solutions do you use? ____________________

What brand or type of lenses do you wear? ____________________

Are you interested in laser vision correction ☐ Y ☐ N

Are you experiencing any difficulty with the following?

Activity	Y/N
Reading small print	☐ Y ☐ N
Reading a newspaper or book	☐ Y ☐ N
Working on the computer	☐ Y ☐ N
Recognizing people when close	☐ Y ☐ N
Seeing steps, stairs, or curbs	☐ Y ☐ N
Bothered by glare/halos	☐ Y ☐ N
Difficulty driving on bright sunny days	☐ Y ☐ N
Difficulty driving at night	☐ Y ☐ N
Reading traffic signs, street signs	☐ Y ☐ N
Doing fine handiwork	☐ Y ☐ N
Writing checks, completing forms	☐ Y ☐ N
Playing games (i.e. bingo, cards)	☐ Y ☐ N
Participating in sports	☐ Y ☐ N
Cooking/Hobbies	☐ Y ☐ N
Watching TV	☐ Y ☐ N