Date:_____

RED ROCK OPHTHALMOLOGY

Name:_____ Date of Birth:_____

Medical/Family Doctor:	Phone Number:
Current Optometrist:	Phone Number:
Pharmacy of Choice:	Phone Number:

Do you wear glasses: Y / N Do you wear contacts: Y / N Hard Soft

Medications: Please include name of medication, dosage, and how you are taking the medication (or bring a copy of your medication list)

1. **Over-the-counter Medications:**

_____

_____

_____

2. **Prescription Medications:**

_____

_____

_____

Surgeries:

_____

_____

History of Trauma/ Major Injuries (including eyes):_____

General Patient Health History: If you have the following health conditions, please check:

X	Past History	Please Explain	X	Past History	Please Explain
☐	Blurred Vision		☐	Dry Eyes / Tearing	
☐	Loss of Vision		☐	Itching (eyeball or eyelid)	
☐	Double Vision		☐	Lumps / bumps in eyelids	
☐	Strabismus / Muscle		☐	Cataracts	
☐	Floaters		☐	Glaucoma	
☐	Flashing Lights		☐	Macular Degeneration	

Family History / Relationship to patient: Mother, Father, Grandparent, Sibling

☐ Cataracts		☐ High Blood Pressure	
☐ Glaucoma		☐ Heart Attacks / Disease	
☐ Macular Degeneration		☐ Cancer / Type / Location	
☐ Retinal Detachment		☐ Kidney Disease	
☐ Diabetes		☐ Strokes	
☐ Strabismus / Muscle Problems		☐ Arthritis	
☐ Hereditary Eye Disease		☐ Thyroid Disease	
☐ Other:			

Ears, Nose, Mouth, Throat

- ☐ Hearing Problems
- ☐ Sinus Problems
- ☐ Throat or Mouth Problems

Cardiovascular – Heart

- ☐ Atrial Fibrillation
- ☐ Abdominal Aortic Aneurysm
- ☐ Angina (chest pain / discomfort)
- ☐ Arrhythmia – Irregular Heartbeat
- ☐ Blood Clots (DVT) *Deep Vein Thrombosis*
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Hypotension
- ☐ Myocardial Infarction-Heart Attack
- ☐ Rheumatic Fever

Respiratory – Breathing

- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ CPAP w/Oxygen
- ☐ CPAP without Oxygen
- ☐ Tuberculosis

Gastrointestinal Disease – Stomach

- ☐ Acid Reflux – Heartburn
- ☐ Colitis – Ulcerative
- ☐ Diverticulitis / Diverticulosis
- ☐ Gastric Stomach Ulcer
- ☐ Hiatal Hernia
- ☐ Irritable Bowel Syndrome (IBS)

Genitourinary

- ☐ Bladder Incontinence
- ☐ Chronic Dialysis
- ☐ Cystitis – (UTI) *Urinary Tract Infection*
- ☐ Enlarged Prostate
- ☐ Kidney Stones
- ☐ Prostate Cancer
- ☐ Renal Insufficiency
- ☐ Renal Failure
- ☐ Uterine Disease

Integumentary Disease (Skin)

- ☐ Eczema
- ☐ Psoriasis

Musculoskeletal (muscles, joints, bones)

- ☐ Arthritis
- ☐ Arthritis (Rheumatoid)
- ☐ Gout
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Polymyalgia

Neurological

- ☐ ADHD / ADD
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Anxiety
- ☐ Depression
- ☐ Speech Delay
- ☐ Down Syndrome
- ☐ Cerebral Palsy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Polio
- ☐ Neuropathy
- ☐ Parkinson's
- ☐ Fibromyalgia
- ☐ Psychiatric Disorder
- ☐ Seizure Disorder
- ☐ Mini Strokes (TIA)
- ☐ Stroke (CVA)

Hematologic / Lymphatic (Blood)

- ☐ Anemia
- ☐ Bleeding Disorder
- ☐ Blood Transfusions
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Malignant Hyperthermia

Endocrine

- ☐ Diabetes Mellitus, Type 1 (insulin)
- ☐ Diabetes Mellitus, Type 2 (diet controlled)
- ☐ Diabetes Mellitus, Type 2 (oral meds)
- ☐ Diabetes Mellitus, Type 2 (insulin)
- ☐ Thyroid Disease
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Other _____

Allergic / Immunologic

- ☐ AIDS

Allergies to:

- ☐ Medications _____
- ☐ Environmental _____
  - ☐ Seasonal _____
- ☐ Food _____
  - ☐ Latex _____
- ☐ Hay Fever
- ☐ HIV
- ☐ Lupus Erythematous
- ☐ Myasthenia Gravis

Cancer

- ☐ Bladder
- ☐ Breast
- ☐ Colon
- ☐ Hodgkin's
- ☐ Non-Hodgkin's
- ☐ Prostate
- ☐ Skin
- ☐ Basal Cell
- ☐ Squamous Cell
- ☐ Melanoma
- ☐ Leukemia
- ☐ Lung
- ☐ Lymphoma
- ☐ Ovarian
- ☐ Thyroid ☐ Uterine
- ☐ Other_____

History of Infection Disease

- ☐ Chicken Pox
- ☐ Herpes Zoster – Shingles
- ☐ Shingles Vaccine
- ☐ MRSA ☐ Meningitis

Genetic Disorders

- ☐ Chromosome Abnormality
- ☐ Syndrome or identified genetic disease
- ☐ Retinitis pigmentosa
- ☐ Color blindness
- ☐ Other _____

Please list any other health condition you may have that has not been listed:_____

_____