KOZIOL - THOMS EYE ASSOCIATES

Patient Name:

Current Eye Symptoms - *Are you currently experiencing any of the following?*

__ *Double Vision* __ *Flashes or floaters* __ *Dryness/Irritation* __ *Itching*
__ *Lid bump(s)* __ *Pain* __ *Something in the Eye* __ *Tearing*
__ *Vision Change/Loss* __ *Other:* _____

Current Eye Problems - *Do you currently have or been diagnosed with:*

__ *Cataract* __ *Diabetic Eye Problems* __ *Dry Eye* __ *Glaucoma*
__ Macular Degeneration __ Retinal Problems __ Other: _____

History of Eye Surgery - *Have you ever had the following?*

__ *Glaucoma Surgery* __ *Cataract Surgery* __ *Injections* __ *Laser Surgery*
__ *Lasik Surgery* __ *Retinal Surgery* __ *Other:* _____

Current Conditions - *Do you currently have or been diagnosed with:*

General
__ Fever
__ Fatigue
__ Other:

Ear, Nose, Throat
__ Hearing Loss
__ Sinus Problems
__ Other

Cardiovascular
__ Atrial Fibrillation
__ Heart Disease
__ Hypertension
__ Stroke
__ Other

Respiratory
__ Asthmas
__ Emphysema
__ Shortness of Breath
__ Other:

Gastrointestinal
__ Intestinal Problems
__ Other

Urinary
__ Kidney Disease
__ Urinary Symptoms
__ Other

Musculoskeletal
__ Arthritis
__ Muscle/Joint/Back Pain
__ Other

Skin
__ Herpes
__ Rash/Itching
__ Rosacea
__ Shingles
__ Skin Cancer
__ Other

Neurological
__ Migraine
__ Multiple Sclerosis
__ Seizures
__ Other

Psychiatric
__ Memory Loss
__ Depression
__ Other

Endocrine
__ Diabetes
__ Thyroid Disease
__ Other:

Blood
__ Anemia
__ Cholesterol
__ Other

Allergic/Immunologic
__ Seasonal Allergies
__ Lupus
__ Other

__ Pregnant
__ Nursing
__ Other

Social History - Do you currently:

__ Drink Alcohol How much _____
__ Current Smoker How much _____
__ Past Smoker Quit when _____
__ Exercise How often _____

What is your current occupation: _____

Medication Allergies: _____

Current Medications: (Name, Strength, How Often)

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____