Dr. Yoos Eye Care & Optical
2692 Bella Vista Way
Bella Vista, AR 72714-3704

Patient Name _____ **Date** _____

Patient Ocular History

	Yes	No
Glaucoma	___	___
AMD	___	___
Ret Detach	___	___
Cataract	___	___
Amb/Str	___	___
Blindness	___	___
Lazy Eye	___	___
Color Blind	___	___
Double Vision	___	___
Eye Infection	___	___
Flashers	___	___
Floaters	___	___

Other Ocular Conditions:

Eye Surgeries:

Eye Injuries:

Patient Medical History

	Yes	No
Diabetes	___	___
HTN	___	___
Thyroid	___	___
CVD	___	___
Cancer	___	___
Arthritis	___	___
Asthma	___	___
Emphysema	___	___
Headaches	___	___
Diabetes Type 1	___	___
Diabetes Type 2	___	___

__Insulin __Non-Insulin __a1C

Other Family Medical Conditions:

Height: ___ft ___in

Weight: ____lbs

Family Ocular History

	M	F	SIB	PGM	PGF	MGM	MGF	NO
Glaucoma	__	__	__	__	__	__	__	__
AMD	__	__	__	__	__	__	__	__
Ret Detach	__	__	__	__	__	__	__	__
Cataract	__	__	__	__	__	__	__	__
Amblyopia	__	__	__	__	__	__	__	__
Blindness	__	__	__	__	__	__	__	__

Other Family Ocular Conditions: _____

_____

Family Medical History

	M	F	SIB	PGM	PGF	MGM	MGF	NO
Diabetes	__	__	__	__	__	__	__	__
HTN	__	__	__	__	__	__	__	__
Thyroid	__	__	__	__	__	__	__	__
CVD	__	__	__	__	__	__	__	__
Cancer	__	__	__	__	__	__	__	__

Other Family Medical Conditions: FHx UNKN ___

HTN = HIGH BLOOD PRESSURE
AMB/STR = CROSS EYED
MGM = MOTHER'S MOM
Social History:

CVD = CARDIVASCULAR DISEASE
SIB = SIBLING
MGF = MOTHER'S DAD

AMD = MACULAR DEGENERATON
PGM = FATHER'S MOM
PGF = FATHER'S DAD

Medications: _____

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Please complete each item; thank you!

Social History

Race:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race
- ☐ Patient Declined to Specify
- ☐ White

Ethnicity

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown
- ☐ Patient Declined to Specify

Preferred Language (please write in) _____

Smoking Status

- ☐ Current smoker
- ☐ Former smoker
- ☐ Never a smoker

*Please circle yes or no on these last items; thank you!

Alcohol Use	Yes	No
Illegal Drug Use	Yes	No
Are you pregnant?	Yes	No
Breast feeding?	Yes	No
Had flu shot?	Yes	No
Been exposed to any sexually transmitted diseases?	Yes	No

Please list all current medications, noting name and delivery method (ex: aspirin, tablet).

_____
_____
_____
_____
_____
_____
_____

Current Eye Drop Therapy _____
_____
_____

Allergies: _____
_____
_____
_____

Primary Care Physician: _____

Review of Systems

Do you currently, or have you **ever had any problems in the following areas?**

System	YES	NO	?
CONSTITUTIONAL			
Fever, weight loss/gain			
INTEGUMENTARY (skin)			
Headaches			
Migraines			
Seizures			
EYES			
Glaucoma			
Loss of vision			
Blurred Vision			
Distorted Vision/Halos			
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			
Chronic Infection of Eye or Lid			
Sites of Chalazion			
Flashers/Floaters in Vision			
Tired Eyes			
ENDOCRINE			
Thyroid/Other glands			
CONNECTIVE TISSUE			
Lupus			
Auto immune Disease			
Other			

	YES	NO	?
EARS, NOSE, MOUTH/THROAT			
Allergies/Hay Fever			
Sinus Congestion			
Runny Nose			
Post Nasal Drip			
Chronic Cough			
Dry Throat/ Mouth			
RESPIRATORY			
Asthma			
Chronic Bronchitis			
Emphysema			
VASCULAR/CARDIOVASCULAR			
Diabetes			
Heart Pain			
High Blood Pressure			
Vascular Disease			
GASTROINTESTINAL			
Diarrhea			
Constipation			
GENITOURINARY			
Genitals/Kidney/Bladder			
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis			
Muscle Pain			
Joint Pain			
LYMPHATIC/HEMATOLOGIC			
Anemia			
Bleeding problems			
ALLERGIC/IMMUNOLOGIC			
Any issues?			
PSYCHIATRIC			
Any Issues?			

If you answered YES to any of the above or **HAVE A CONDITION NOT LISTED, please explain** and **list medications:**

_____

_____

I do hereby authorize release of any medical information necessary to process insurance claims and accept personal responsibility for the of the charge for services rendered.

I have read and understand the above:

Signature of patient and/or responsible party: _____

Doctor Signature: _____ Date: _____