

Welcome



Dr. Kathleen Murphy
Dr. Stephen Denny
Dr. Susan Wright
Dr. Jenna Tyler

Patient Name: _____ Date of Birth: _____
Social Security Number: _____ Employer/School: _____ Position: _____
Preferred email address: _____
What is the main reason for your visit today? _____

Personal Eye Problems

Are you having any (circle): Redness / Burning / Itching / Tearing / Discharge
Have you had any (circle): Cataracts / Macular Degeneration / Glaucoma / Diabetes/ Dryness/ Infection/
Floaters or Flashes/ Iritis or Uveitis/ Retinal Defects

Personal Health

Do you have or have you ever had any problems in the following areas? (Please circle)

- Constitutional: Developmental Disabilities, Cancer, Fatigue Syndrome
- Ears, Nose, Throat: Hearing Loss, Sinusitis, Dry Throat/Mouth, Laryngitis
- Neurological: MS, Epilepsy, Cerebral Palsy, Tumor, Stroke/CVA, Migraines, Autism
- Psychiatric: Depression, Attention Deficit, Anxiety, Bipolar Disorder
- Cardiovascular: High Blood Pressure, Stroke, Heart Disease, Congestive Heart Failure
- Respiratory: Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea
- Gastrointestinal: Crohn's Disease, Colitis, Ulcer, Acid Reflux, Celiac Disease
- Genitourinary: Kidney disease, Prostate cancer, STD-Herpetic or Chlamydia, Benign Prostate Hypertrophy, Currently Pregnant or Nursing
- Muscles/Skeletal: Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
- Integumentary: Eczema, Acne Rosacea, Psoriasis, Cold sores, Shingles
- Endocrine: Diabetes Type I or Type II, Thyroid Dysfunction, Hormone Dysfunctions
- Lymphatic/Hematologic: Anemia, History of Large Blood Loss, Ulcer, High Cholesterol
- Allergic/Immunologic: Allergies (Medication or Environment or Latex), Rheumatoid Arthritis, Lupus, Sjogren's Syndrome

List current Medications/vitamins/supplements and dosages: _____

List any Allergies (Medication or Environment): _____

List any previously diagnosed Eye Diseases: _____

Do you use any of the following products?

| | | | | |
|---------|-----|----|---------------|----------------------|
| Alcohol | Yes | No | Amount: _____ | per day/ week/ month |
| Tobacco | Yes | No | Amount: _____ | per day/week/ month |

Family History: (please circle)

| | | | | | | |
|--------------------------------------|--------|--------|---------|--------|-----|----------|
| Cataracts: | Father | Mother | Brother | Sister | Son | Daughter |
| Macular Degeneration: | Father | Mother | Brother | Sister | Son | Daughter |
| Glaucoma: | Father | Mother | Brother | Sister | Son | Daughter |
| Cancer: | Father | Mother | Brother | Sister | Son | Daughter |
| Diabetes Type I or II (circle type): | Father | Mother | Brother | Sister | Son | Daughter |
| High Blood Pressure: | Father | Mother | Brother | Sister | Son | Daughter |
| Overactive/ Hyperthyroid: | Father | Mother | Brother | Sister | Son | Daughter |
| Underactive/ Hypothyroid: | Father | Mother | Brother | Sister | Son | Daughter |