Tekwani Vision Center

_____ _____/_____/_____
Patient Name Date of Birth

Do you have now, or have you ever had:
(Please circle any that apply to you)

PROBLEM

Decreased Hearing
Cancer
Type _____
Treatments_____
Angina
Heart Attack
High/Low Blood Pressure
High Cholesterol
Murmur
Thrombophlebitis
Varicose Veins
Congestive Heart Failure
Raynaud's Disease

COPD
Asthma
TB
Chronic Bronchitis
Sarcoidosis

Rosacea
Dermatitis
Psoriasis
Poison Ivy
Shingles
Affected Area _____
Eczema
Blepharitis

Hemorrhoids
Chron's Disease
Colitis
G.I. Cancer
Ulcer
Hiatus Hernia

BPH
Enlarged Prostate
Frequent UTIs
Incontinence
Kidney Stones
Renal Cancer

Diabetes
Hypoglycemia
Goiter
Hypothyroidism
Hyperthyroidism

PROBLEM

Alzheimer's
Epilepsy
Headaches
Migraines
MS
Neuropathy
Paralysis
Parkinson's Disease
Seizures
Stroke
TIAs
Tremor
Brain Tumor
TBI
Bell's Palsy

Depression
Mania
Anxiety
Panic Attacks
Past Suicide Attempts

Anemia
Lymphoma Leukemia
Hemophilia
Factor Deficiency Disease

Rheumatoid Arthritis
Osteoarthritis
Lyme Disease
Muscular Dystrophy
Polymyalgia Rheumatica
Fibromyalgia

Social History

Do you smoke?
□ Yes □ No
Do you drink alcohol?
□Yes □No
Do you drive?
□Yes □No
Do you live alone?
□Yes □No

Height _____
Weight _____

Average Blood Pressure
_____/_____

Are you pregnant or nursing? □Yes □No

Are there any other health issues we should be aware of? _____
_____
_____
_____

Are you allergic to anything that you know of?
Yes □ No
If yes, please list, _____
_____
_____
_____

Please list all medications you take on a daily basis

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you have any **personal or family history** of any of the following;

	Self-Fa**mily Relation**	
Glaucoma	□	□ _____
Macular Degeneration	□	□_____
Diabetes	□	□_____
Retinal Disease	□	□ _____
Lazy Eye (or Eye Turn)	□	□ _____
Blindness	□	□ _____
Color Blind	□	□ _____
Light Sensitivity	□	□ _____
Dry Eyes	□	□ _____
Floaters	□	□ _____
Eye Injury	□	□ _____