SARATOGA VISION

Today's Date_____

Patient Name _____ DOB _____ Gender: M F

Address _____

Home Phone _____ Cell Ph._____ Work Ph._____

Email Address_____SS #_____

Patient Employer/School_____Occupation/Grade_____

---

What is the main reason for your visit today? □ Routine Exam □Other _____

Primary Care Physician_____ Last Exam Date _____

Medications □ None

_____

_____

_____

Medication Allergies □ None

_____

_____

_____

Review of Systems

Constitutional
□ Weight Loss □ Other
□ Fever
□ Fatigue

Psychiatric
□ Depression □ Other
□ Panic Disorder
□ Schizophrenia

GI
□ Crohn's Disease □ Other
□ Colitis
□ Ulcer

Integumentary
□ Eczema □ Other
□ Psoriasis
□ Rosacea

Ears Nose Throat
□ Hearing Loss □ Other
□ Sinusitis
□ Laryngitis

Cardiovascular
□ Heart Disease □ Other
□ High Blood Pressure
□ Congestive Heart Failure

GU
□ Kidney Disease □ Other
□ Prostate Disease
□ Pregnant or Nursing

Endocrine
□ Type 1 Diabetes □ Other
□ Type 2 Diabetes
□ Thyroid Dysfunction

Neurological
□ Epilepsy □ Other
□ Multiple Sclerosis
□ Migraine

Respiratory
□ Cigarette Smoker □Other
□ Asthma
□ Bronchitis

Musculoskeletal
□ Arthritis □ Other
□ Fibromyalgia
□ Osteoarthritis

Hematological
□ Anemia □ Other
□ Leukemia

Allergic/Immunological
□ Environmental □ Other
□ Rheumatoid Arthritis

**Eye History**

Date of Last Eye Exam _____

Where_____
Do you wear Contact Lenses □ Yes □ No
Brand_____

Solution _____

Do you consume any alcohol ? □ Yes □ No
Do you use any tobacco products? □ Yes □ No

Have **you** ever been Diagnosed or Treated for:

□ Amblyopia/ Lazy Eye
□ Cataracts
□ Corneal Abrasion
□ Dry Eye
□ Eye Infection
□ Eye injury or Surgery
□ Glaucoma
□ Iritis/ Uveitis
□ Macular Degeneration
□ Retinal Detachment

**Family History**

Is there any family history of the following? If yes, List who

□ Diabetes _____□ High Blood Pressure _____
□ Strabismus _____□ Amblyopia_____
□ Macular Degeneration_____
□ Cataracts _____□ Glaucoma_____