

Dr. Signature _____
Date _____

Welcome to Golden Eye Clinic

Dr. D. Dixon Golden
Therapeutic Optometrist, Glaucoma Specialist

Name _____ Date of Birth _____ Date of Last Physical Exam _____

Please check the box for any of the following conditions that apply to you:

EYES/OCULAR SYMPTOMS:

- | | | |
|--|---|--|
| <input type="checkbox"/> Decreased distance vision | <input type="checkbox"/> Chronic eye or lid infection | <input type="checkbox"/> Sandy or gritty feeling |
| <input type="checkbox"/> Decreased near vision | <input type="checkbox"/> Flashing lights/floaters | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Loss of side vision | <input type="checkbox"/> Headache | <input type="checkbox"/> Pain or soreness |
| <input type="checkbox"/> Fluctuating vision | <input type="checkbox"/> Mucous discharge | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Glare/light sensitivity | <input type="checkbox"/> Dryness | |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Itching | |

REVIEW OF SYSTEMS:

CONSTITUTIONAL

- Fever
- Weight loss/gain

CARDIOVASCULAR

- Hypertension
- Stroke
- Heart disease/problems
- High cholesterol

EARS, NOSE, MOUTH, THROAT

- Sinus infection
- Ear infection
- Hearing loss

RESPIRATORY

- Asthma/shortness of breath
- Bronchitis/emphysema

GASTROINTESTINAL

- Gastric reflux
- Liver problems

GENITOURINARY

- Genitals/Kidney/Bladder

MUSCULOSKELETAL

- Rheumatoid arthritis
- Joint/muscle/back pain

INTEGUMENT

- Rosacea
- Metal allergies
- Skin cancer

NEUROLOGICAL

- Headaches
- Seizures
- Alzheimer's/Parkinson's

PSYCHIATRIC

- Depressed/mood swings
- Nervousness

ENDOCRINE

- Diabetes
- Thyroid/other glands

LYMPHATIC/HEMATOLOGIC

- Anemia
- Blood disorders

ALLERGIC/IMMUNOLOGIC

- Allergies/hayfever
- HIV
- Lupus

DRUG ALLERGIES _____

PAST/PRESENT EYE HISTORY:

- | | | |
|---|---|--------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Retinal disease (hole, etc.) | <input type="checkbox"/> Dry eye |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Blindness | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Eye turn/lazy eye | |
| <input type="checkbox"/> Eye injury (black eye, etc.) | <input type="checkbox"/> Diabetic retinopathy | |

FAMILY HISTORY:

- | | | |
|---|--|--|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blindness | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Strabismus (eye turn) | <input type="checkbox"/> Hypertension |
| <input type="checkbox"/> Macular degeneration | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Retinal disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other _____ |

LIST MEDICATIONS BELOW:

- Name _____
- Name _____
- Name _____

SURGERIES:

- Date _____ Surgery _____
- Date _____ Surgery _____
- Date _____ Surgery _____

SOCIAL HISTORY:

USE OF

- Alcohol
- Tobacco products
- Drugs

Would you prefer to be dilated today or have an optomap test (no dilation required) for an additional \$25?

Please check one: _____ Dilation _____ Optomap (\$25 extra)

PATIENT'S SIGNATURE _____

Today's Date _____