THE HAMMOND EYE CLINIC

NAME _____ DATE _____

PLEASE CIRCLE "YES" OR "NO" FOR THE FOLLOWING. ALSO PLEASE CIRCLE IF ANY BLOOD RELATIVES HAVE THE FOLLOWING.

	SELF	FAMILY		SELF	FAMILY
AIDS/HIV	YES NO	YES NO	HIGH BLOOD PRESS	YES NO	YES NO
ARTHRITIS	YES NO	YES NO	KIDNEY DISEASE	YES NO	YES NO
ASTHMA	YES NO	YES NO	LUPUS	YES NO	YES NO
CANCER	YES NO	YES NO	RHEUMATIC FEVER	YES NO	YES NO
DRUG USE	YES NO	YES NO	SEIZURE DISORDER	YES NO	YES NO
DIABETES	YES NO	YES NO	SHINGLES	YES NO	YES NO
EMPHYSEMA	YES NO	YES NO	SKIN CONDITION	YES NO	YES NO
GLAUCOMA	YES NO	YES NO	STROKE	YES NO	YES NO
HEART DISEASE	YES NO	YES NO	THYROID	YES NO	YES NO
HEPATITIS _____	YES NO	YES NO	TUBERCULOSIS	YES NO	YES NO
SMOKER?	YES NO		DO YOU DRINK?	YES NO	
PREGNANT?	YES NO		HOW MANY CHILDREN? _____		

PLEASE CIRCLE ANY OF THE FOLLOWING EYE PROBLEMS AS THEY RELATE TO YOURSELF.

BLINDNESS	YES NO	FAINTING SPELLS	YES NO
BLOODSHOT EYES	YES NO	FLOATERS OR SPOTS	YES NO
BLURRY DISTANCE VISION	YES NO	GLAUCOMA	YES NO
BLURRY NEAR VISION	YES NO	HEADACHES	YES NO
CATARACTS	YES NO	ITCHING OR BURNING	YES NO
POOR COLOR VISION	YES NO	LAZY EYES	YES NO
CROSSED EYES	YES NO	LIGHT SENSITIVE	YES NO
DISCHARGE FROM EYES	YES NO	MIGRAINE HEADACHES	YES NO
DIZZY SPELLS	YES NO	POOR NIGHT VISION	YES NO
DOUBLE VISION	YES NO	RETINAL DISEASE	YES NO
DRY EYES	YES NO	SEEING HALOS	YES NO
EYE INFECTION	YES NO	SEEING FLASHES	YES NO
EYE INJURY	YES NO	TEMPORARY LOSS OF VISION	YES NO
EYE SURGERY	YES NO	TWITCHING EYELID	YES NO
EYE STRAIN	YES NO	WATERING EYES	YES NO

DO YOU WEAR GLASSES? YES NO DO YOU WEAR CONTACTS? YES NO
ALL THE TIME ---- OCCASIONALLY ---- TV ---- DRIVING ----- READING

WHEN WAS YOUR LAST EYE EXAM? _____

LIST MEDICATIONS INCLUDING EYE DROPS _____
_____
_____

ANY MEDICATION ALLERGIES? _____
_____

PRIMARY CARE PHYSICIAN _____