INSIGHT VISION GROUP

To be completed by patient or family:

Name:____ Age :______________ **Date**:_________________________________

Chief Problem:____

Referred by:____ Phone:____

Known Eye Problems:	Onset	R	L
Cataracts________________	_________	____	____
Injury__________________	_________	____	____
Farsighted/Nearsighted _____	_________	____	____
Lazy Eye _______________	_________	____	____
Retinal Disease ____________	_________	____	____
Corneal Disease____________	_________	____	____
Glaucoma_________________	_________	____	____

Previous Eye Surgery:	
Right Eye _________	Left Eye___________
___________________	__________________
___________________	__________________
___________________	__________________
___________________	__________________
___________________	__________________
___________________	__________________

Present Eye Medications:

List all **Allergies** Below:

Name (circle below):	Year Started	Which Eye(s)	How often?	Used Before?	
Alphagan (P)/Brimonidine	__________	R L Both	1 2 3 4	Y	N
Azopt	__________	R L Both	1 2 3 4	Y	N
Betagan (levobunolol)	__________	R L Both	1 2 3 4	Y	N
Betaxolol or Carteolol	__________	R L Both	1 2 3 4	Y	N
Combigan	__________	R L Both	1 2 3 4	Y	N
Cosopt	__________	R L Both	1 2 3 4	Y	N
Diamox or Neptazane Pill	__________	________mg	1 2 3 4	Y	N
Dipivefrin (Propine)	__________	R L Both	1 2 3 4	Y	N
Doxycycline Pill	__________	________mg	1 2 3 4	Y	N
Lumigan	__________	R L Both	1 2 3 4	Y	N
Ocupress/OptiPranolol	__________	R L Both	1 2 3 4	Y	N
Ointment: ________	__________	R L Both	1 2 3 4	Y	N
Pilocarpine (GEL?)	__________	R L Both	1 2 3 4	Y	N
Restasis:	__________	R L Both	1 2 3 4	Y	N
Steroid Eye Drop	__________	R L Both	1 2 3 4	Y	N
Timoptic/timolol	__________	R L Both	1 2 3 4	Y	N
Travatan	__________	R L Both	1 2 3 4	Y	N
Xalatan	__________	R L Both	1 2 3 4	Y	N
Vigamox/Zymar	__________	R L Both	1 2 3 4	Y	N
Other:	__________	R L Both	1 2 3 4	Y	N
Other:	__________	R L Both	1 2 3 4	Y	N

Visual Symptoms:

Do you have trouble reading?	Y	N	Sudden Visual loss?	Y	N
Can you read small print?	Y	N	Gradual Vision Loss?	Y	N
Can you read large print?	Y	N	Night Blindness?	Y	N
Can you recognize people?	Y	N	Double Vision?	Y	N
Can you see steps?	Y	N	Halos?	Y	N
Can you read signs?	Y	N	Sensitivity?	Y	N
Can you see to do fine handwork?	Y	N	Eye Pain?	Y	N
Can you see to write checks?	Y	N	Headaches?	Y	N
Can you see to play table games?	Y	N	Eyes Itch?	Y	N
Can you see to play sports?	Y	N	Other Eye Symptoms:		
Can you see to cook?	Y	N	Highest Eye Pressure & Date:		
Trouble watching TV?	Y	N			
Currently Drive?	Y	N	Dr. Comments:		

***Medical History on other side:

Active Medical Problems: (Please check all that apply)

- Asthma
- Diabetes
- High blood pressure
- Heart disease
- Stroke
- Migraines
- TB
- Hepatitis
- HIV
- Seizures
- Blood disorder
- Psychiatric condition
- Nervous condition
- Temporal arteritis
- Arthritis
- Skin disorder

Social History

Do you smoke?	Y	N
Do you drink alcohol?	Y	N
Any occupational hazard exposure?	Y	N

Current General Medications:

____
____
____
____
____
____
____
____
____
____
____

Other Medical and Surgical History: Please write out problems and year it occurred:

____
____
____
____
____

Family History: (please check all that apply and note whom was affected: F=Father M=Mother S=Sister B=Brother C=Child A=Aunt U=Uncle GP=Grandparent O=Other)

()	Glaucoma	______________	()	Diabetes	______________
()	Cataracts	______________	()	Heart	______________
()	Corneal disease	______________	()	Stroke	______________
()	Retinal disease	______________	()	Cancer	______________
()	Similar problem	______________	()	Other	______________

System Review: (circle symptoms that apply to you)

General:	fatigue weight loss fevers chills tired
Skin:	rash blisters dry patches spots
Nose, Ears and Throat:	nasal drip sinus infections poor hearing sore throat dry mouth missing teeth
Heart:	palpitations chest pain short of breath sleep with head elevated irregular heart beat
Lungs:	cough wheezing gasping pneumonia
Abdomen:	stomach pain diarrhea bleeding pain tenderness
Muscles:	weak lifting arms or climbing steps no strength
Bones:	osteoporosis joint pain easy fractures
Genito-urinary:	kidney stones burning with urination incontinence pregnant
Nervous system:	tremor imbalance