Beri Eye Care Associates, PC

Full Legal Name:_____ **DOB:**_____ **Date:**_____

Date of last eye exam: _____ Place of last eye exam:_____

Do you currently wear glasses? ☐ Yes ☐ No How old are your glasses? _____
Have you ever worn contact lens? ☐ Yes ☐ No
Currently wear contact lens? ☐ Yes ☐ No
Type of contacts: _____(soft, rigid gas permeable)

Mark all symptoms that currently apply to you: **R**= Right eye **L**= Left eye **B=** Both eyes

___ None
___ Vision decline/blurry (distance/near/both)
___ Loss of vision (central - peripheral)
___ Problems with night vision
___ Glare/ Halos
___ Headache or migraine
___ Tired eyes
___ Distorted vision
___ Double vision
___ Fluctuating vision
___ Light flashes
___ Floaters
___ Light sensitivity
___ Pain in or around eyes
___ Drooping eyelid
___ Dryness
___ Burning
___ Excess tearing or watering
___ Crusting or discharge
___ Red eye
___ Foreign body sensation
___ Itching eyes
___ Irritated eyes

Past ocular history: ☐ None

☐ Retinal tear/detachment: Onset:_____ ☐ Cataract: Onset:_____
☐ Macular Degeneration: Onset:_____ ☐ Glaucoma: Onset:_____
☐ Diabetic retinopathy: Onset:_____ ☐ Lazy eye: Onset:_____
☐ Other:_____ Onset:_____

Have you ever had any of the following eye surgeries? ☐ None

☐ Cataract: Date:_____ ☐ Glaucoma: Date:_____
☐ Lasik: Date:_____ ☐ PRK: Date:_____
☐ RK: Date:_____ ☐ RD: Date:_____
☐ Other: _____ Date:_____

Family History: ☐ None ☐ Family History not known

Please indicate: M-mother, F- father, S-sister, B-brother, Grandparents (Maternal or Paternal)

- ☐ Macular Degeneration _____
- ☐ Blindness Lazy eye _____
- ☐ Retinal tear / Detachment _____
- ☐ Hypertension_____
- ☐ Cataract _____
- ☐ Diabetes _____
- ☐ Migraines _____
- ☐ Glaucoma _____

Current Medication List (prescription, over the counter, vitamins, homeopathic)**:** ☐ None

_____ _____ _____

_____ _____ _____

List all Allergies: ☐ None

_____ _____ _____

_____ _____ _____

List all major illnesses or injuries: ☐ None

☐ Endocrinologist: _____☐ Rheumatologist: _____

- ☐ Diabetes: Year of Onset:_____ ☐ Insulin ☐ Diet Controlled ☐ Oral Medication
- ☐ Arthritis ☐ Emphysema ☐ Recent injury/ fall
- ☐ Asthma ☐ Heart Attack ☐ Sleep Apnea
- ☐ Atrial Fibrillation ☐ Hypertension ☐ Stroke
- ☐ Cholesterol ☐ Kidney failure/ Dialysis ☐ Thyroid Disease
- ☐ Cancer/ Type:_____ ☐ Date of Onset:_____
- ☐ Other:_____ ☐ Date of Onset:_____

List any Surgeries, Radiation or Chemotherapy you ever had: with dates, if known ☐ None

_____ _____ _____

_____ _____ _____

Review of Systems: Please check any condition you are experiencing today:

General/ Constitutional: ☐ None ☐ Fever ☐ Weight loss ☐ Headache

Ears, Nose, Throat: ☐ None ☐ Earache ☐ Vertigo ☐ Hard of hearing
☐ Nasal Congestion

Cardiovascular: ☐ None ☐ Chest Pain ☐ Irregular/ Rapid Heartbeat

Respiratory: ☐ None ☐ C-PAP ☐ Asthma ☐ Emphysema
☐ Shortness of Breath

Gastrointestinal: ☐ None ☐ Change in bowel habits ☐ Diarrhea
☐ Reflux

Genital, Kidney, Bladder: ☐ None ☐ Frequent urination ☐ Burning /Painful urination

Musculoskeletal: ☐ None ☐ Arthritis ☐ Gout ☐ Joint/Muscle pain
☐ Joint/ Muscle weakness

Skin: ☐ None ☐ Rosacea ☐ Eczema ☐ Acne
☐ Rash

Neurological: ☐ None ☐ Dizziness ☐ Headache ☐ Weakness
☐ Numbness ☐ Memory loss

Psychiatric: ☐ None ☐ Anxiety ☐ Depression ☐ Emotional changes

Endocrine: ☐ None ☐ Diabetes ☐ Thyroid Disease

Blood / Lymph: ☐ None ☐ Fatigue ☐ Easy Bruising
☐ Bleeding disorder

Allergic/ immunologic: ☐ None ☐ Hay fever ☐ Sneezing ☐ Coughing
☐ Seasonal Allergies ☐ Year-round Allergies

Social History:

Do you drive? ☐ Yes ☐ No

Residence: ☐ Private home with: ☐ Assistance ☐ NO assistance
☐ Foster Care ☐ Retirement Home ☐ Assisted living home

Do you speak English? ☐ Yes ☐ No _____(What language?)

Do you drink Alcohol? ☐ No ☐ Yes ☐ Occasional ☐ 1/day ☐ 2-3/day ☐ 4+/day

Do you smoke? ☐ No ☐ Yes ☐ Occasional ☐ ½ Pk/day ☐ 1 Pk/day ☐ 1+ Pk/day

Have you EVER smoked? ☐ No ☐ Yes/Year Quit: _____

Recreational Drug Use? ☐ No ☐ Yes: _____(Type used?)

Additional Comments:

Patient/Guardian Signature_____Date:_____

Physician Initials_____Date:_____

History Reviewed:

Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____

Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____
Physician Review(initials)_____Date:_____