BVA Advanced Eye Care

Patient Name: _____
DOB: _____

- ***Medical History*** *- Please ☑ check all that apply:*

☐ Blindness
☐ Cataracts
☐ Diabetic Retinopathy
☐ Glaucoma
☐ Macular Degeneration
☐ Retinal Detachment
☐ Arthritis (Type_____)
☐ Cancer
☐ Heart Disease
☐ High Blood Pressure
☐ High Cholesterol
☐ Diabetes - If yes, year diagnosed: _____ Most recent blood sugar reading:_____:AIC
☐ Kidney Disease
☐ Lung Disease
☐ Lupus
☐ Stroke
☐ Thyroid
☐ AIDS/HIV
☐ Bleeding/Clotting
☐ Ever taken Flomax?
☐ Hepatitis (Type_____)
☐ Sleep Apnea
☐ Other: _____
☐ Sjogren's
☐ Alzheimer's/Dementia

- ***Family History - Ocular Disease*** *- Please ☑ check if a family member has any of the following:*

☐ Macular Degeneration
Family relation: _____
☐ Glaucoma
Family relation: _____
☐ Diabetes
Family relation: _____

- ***Social History***

Are you pregnant? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No Packs per day? _____ # of Years? _____
Previous smoker? ☐ Yes ☐ No Year quit _____Packs per day?_____ # of Years? _____
Do you drink alcohol? ☐ Yes ☐ No Drinks per week:_____
Do you drive? ☐ Yes ☐ No
Do you have visual difficulty when driving/or problems with night vision? ☐ Yes ☐ No
Do you wear contacts? ☐ Yes ☐ No Type_____ Hours per day_____ Date last worn_____
Do you wear glasses? ☐ Yes ☐ No

- *Please ☑ check "YES" or "NO" to indicate if you are <u>currently experiencing</u> any of the following:*

Loss of Vision	☐ Yes	☐ No	Distorted Vision	☐ Yes	☐ No
Fluctuated Vision	☐ Yes	☐ No	Double Vision	☐ Yes	☐ No
Loss of Side Vision	☐ Yes	☐ No	Mucus	☐ Yes	☐ No
Dryness	☐ Yes	☐ No	Sandy or Gritty Feeling	☐ Yes	☐ No
Redness	☐ Yes	☐ No	Foreign Body Sensation	☐ Yes	☐ No
Burning or Itchy	☐ Yes	☐ No	Glare and Light Sensitivity	☐ Yes	☐ No
Excess Tearing/Watering	☐ Yes	☐ No	Infection of Eyelid	☐ Yes	☐ No
Eye Pain or Soreness	☐ Yes	☐ No	Crossing Eyes	☐ Yes	☐ No
Tired Eyes	☐ Yes	☐ No	Drooping Eyelid	☐ Yes	☐ No
Lazy Eye	☐ Yes	☐ No	Flashes of Light/Floaters	☐ Yes	☐ No
Blurred Vision	☐ Yes	☐ No			

BVA
Advanced Eye Care

Patient Name: _____
DOB: _____

Pharmacy Name: _____ Location: _____ Phone: _____

- *List **Current Medications** (including **EYE** drops):*

Drug Name	Dosage	Times per day

- ***Drug Allergies***

☐ No known allergies ☐ Latex Allergy ☐ Sulfa Allergy ☐ Adhesive Tape

☐ Other/ Medication Allergy _____

Describe Allergic Reaction:_____

- *Please List Your **Height**:_____ **Weight**:_____* [Information required for surgery patients.]

- *Please List All **Past Surgeries & Surgery Dates** (including **EYE** surgeries):*

_____

_____

_____

_____

_____

_____