

# Welcome to Belk Eye Clinic & Optical

Name: Ms. Mrs. \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Mr. Dr. \_\_\_\_\_  
Nickname: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Marital Status: (Please Circle) Single Married Divorced Separated Widowed Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Race: (Please Circle) - Black / African American Social Security #: \_\_\_\_/\_\_\_\_/\_\_\_\_  
- American Indian or Alaska Native - Hispanic / Latino  
- Asian - White / Caucasian  
- Native Hawaiian or Other Pacific Islander - Other Race  
E-mail Address: \_\_\_\_\_ Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Place of Employment: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Name of Medical Doctor: \_\_\_\_\_ Dr.'s Phone: \_\_\_\_\_  
How did you learn about our office? \_\_\_\_\_ Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Guardian (If Applicable) Ms. Mrs. \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Mr. Dr. \_\_\_\_\_  
Address if different than above: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

## Ocular History Main reason for your appointment today? \_\_\_\_\_

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections, eye injury, or eye surgery: \_\_\_\_\_

Are you pregnant and / or nursing?  no  yes  
Do you wear glasses?  no  yes If yes, how old is your present pair of glasses? \_\_\_\_\_  
Do you wear contact lenses?  no  yes If yes, how old is your present pair of lenses? \_\_\_\_\_

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment / Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

## Social History

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you use tobacco products?  no  yes If yes, type / amount / how long: \_\_\_\_\_  
Do you drink alcohol?  no  yes If yes, type / amount / how long: \_\_\_\_\_  
Do you use illegal drugs?  no  yes If yes, type / amount / how long: \_\_\_\_\_  
Have you ever been exposed to or infected with:  Gonorrhea  Hepatitis  HIV  Syphilis  
Do you have any allergies to medications?  no  yes Please List: \_\_\_\_\_

## Review of Systems

Do you currently, or have you ever had any problems in the following areas?:

SYSTEM	NO	YES	?		NO	YES	?
<b>BONES / JOINTS / MUSCLES</b>				<b>IMMUNOLOGIC</b>			
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARDIOVASCULAR / VASCULAR</b>				Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>INTEGUMENTARY / SKIN</b>			
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
<b>CONSTITUTIONAL</b>				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sudden Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EARS, NOSE, MOUTH, THROAT</b>				<b>NEUROLOGICAL</b>			
Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD / ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion / Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bipolar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>				Down's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hashimoto's Thyroiditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GASTROINTESTINAL</b>				Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>			
Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>GENITOURINARY / BLADDER</b>				<b>RESPIRATORY</b>			
Kidney Infections / Stones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Urinary Tract Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**LIST ANY MAJOR SURGERIES / INJURIES:**

---

---

---

---

**LIST ALL CURRENT MEDICATIONS:**

---

---

---

---