EVOLVE EYECARE

Patient Information

Patient Name _____ DOB _____

Changes to address/phone, employment, and insurance (write "N/A" if no changes):

_____

Please list any new medications you are taking : _____

Please list any changes in your general health: _____

Review of Systems

Are you currently experiencing any of the symptoms listed below? ☐ **Yes** ☐ **No**

Eye Symptoms
- ☐ Itching
- ☐ Flashes and/or Floaters
- ☐ Discharge/watering
- ☐ Glare/Light sensitive
- ☐ Pain
- ☐ Eye fatigue
- ☐ Lose place when reading
- ☐ Focus difficulty

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Chest stiffness
- ☐ Palpitations
- ☐ Shortness of breath (dypsnea)

General Symptoms
- ☐ Weight loss
- ☐ Weight gain
- ☐ Chills
- ☐ Fatigue/weakness
- ☐ Fever
- ☐ Trouble sleeping

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Sweating
- ☐ Frequent urination (polyuria)
- ☐ Thirst
- ☐ Poor blood sugar control

Recent blood sugar reading: _____

Recent HbA1c reading: _____

Gastrointestinal
- ☐ Acid reflux
- ☐ Appetite Loss
- ☐ Heartburn
- ☐ Nausea
- ☐ Constipation
- ☐ Diarrhea

Genitourinary
- ☐ Frequency (polyuria)
- ☐ Urgency

Ear, Nose, Mouth, Throat
- ☐ Dry mouth
- ☐ Hearing loss
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus disease/pain
- ☐ Sore throat
- ☐ Stuffiness

Head/Neck
- ☐ Dizziness
- ☐ Headache
- ☐ Pain
- ☐ Ringing in the ears
- ☐ Stiffness

Hematologic/Lymphatic
- ☐ Bruising, easily
- ☐ Bleeding, easily
- ☐ Leg cramps

Integument (Skin)
- ☐ Rashes
- ☐ Itching (pruritis)
- ☐ Dryness
- ☐ Hair and nail changes

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle pain
- ☐ Stiffness

Neurological
- ☐ Fainting
- ☐ Memory loss
- ☐ Numbness
- ☐ Seizures
- ☐ Weakness
- ☐ Tingling
- ☐ Tremors

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia

Respiratory
- ☐ Coughing
- ☐ Shortness of breath
- ☐ Wheezing

Social History

Do you smoke? ☐ Never smoked ☐ Former smoker ☐ Current every day smoker ☐ Smokeless tobacco ☐ Current occasional smoker

When did you stop smoking? _____ years ago

Alcohol usage? ☐ None ☐ 1-2 drinks daily ☐ Social ☐ Above average

Height _____ Weight _____

_____ _____

Signature of patient (if patient is minor, signature of guardian) Date

_____ _____

Reviewed by doctor Date

CONFIDENTIAL INFORMATION