833-509-OCLI
(833-509-6254)

OCLI VISION

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**Patient Name:** **Date of Birth:** **Date:**

| | |
|---|---|
| **Reason(s) for today's visit:** | |
| **Who is your Primary Care Physician (PCP)?** | |
| **Do you currently see any other doctor/specialist for other medical conditions? Yes / No** | |
| **List any medical condition(s) you have:** _____ _____ | **Past Medical History** |
| **List any hospitalizations and/or surgeries with date(s):** _____ _____ | |
| **List any EYE surgery with date(s):** _____ _____ | |
| **List your prescribed medication(s), including vitamins/supplements:** o No Current Meds _____ _____ | |
| **List known allergies (including medication allergies) and reaction:** o None Known Allergies (NKA) _____ | |
| **Have you ever had a reaction to anesthesia?** o Yes o No | |
| **Do you use tobacco?** o Yes o No **Year Quit, if applicable**: | **Social History** |
| **Do you consume alcohol?** o Yes o No **Drinks per week:** | |
| **What is your occupation?** | |
| **Do you have relatives with:** o Blindness o Cataract(s) o Glaucoma o Diabetes oHypertension o Heart Disease o Stroke o Cancer oThyroid Disease o Arthritis o Other _____ o Unknown | **Family History** |

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**Patient Name:** **Date of Birth:** **Date:**

| **Are you currently experiencing any of the following? If yes, circle:** | **YES** | **NO** | |
|---|---|---|---|
| GENERAL/CONSTITUTIONAL: fever, heatstroke, weight loss, weight gain, fatigue, other | | | **Review of Systems** |
| EYES: blurry vision, dry eyes, floaters, light sensitivity, discharge, pain, other | | | |
| EAR, NOSE, THROAT: hard of hearing, congestion, earache, cough, dry mouth, other | | | |
| CARDIOVASCULAR: pacemaker, defibrillator, high or low blood pressure, racing pulse, other | | | |
| RESPIRATORY: congestion, wheezing, short of breath, other | | | |
| GASTROINTESTINAL: stomach upset, diarrhea, constipation, hernia, ulcers, other | | | |
| GENITOURINARY: painful/frequent urination, kidney disease, prostate problems, other | | | |
| FEMALES: pregnant, nursing | | | |
| MUSCULOSKELETAL: joint pain, stiffness, swelling, cramps, arthritis, other | | | |
| SKIN: pimples, warts, growths, rash, other | | | |
| NEUROLOGICAL: numbness, headache, seizure, paralysis, loss of consciousness, other | | | |
| ALLERGIC/IMMUNOLOGIC: redness, itching, hives, Lupus, Sjogren's, other | | | |
| PSYCHIATRIC: anxiety, depression, insomnia, other | | | |
| BLOOD/LYMPH: bleeding, cholesterolemia, anemia, problems with blood transfusion, other | | | |
| CANCER: | | | |
| ENDOCRINE: Type I Diabetes, Type II Diabetes, hypothyroid, other<br>☐ Insulin ☐ Non-Insulin Last blood sugar level Date taken | | | |

**Do you wear glasses for distance?** o Yes o No **Do you wear reading glasses?** o Yes o No

**Do you wear contact lenses?** o Yes o No

**(Type) _____ Contact Lens Wear for ____ years Dispose of every ____ days/weeks/month**

**Patient Signature: _____ Date: _____ Doctor Initials: _____**