Avera Medical Group Eye Care
Plaza 4
911 E. 20th St., Suite 101
Sioux Falls, 57105
605-322-3790

Name _____ Today's Date _____
Age _____ Birthdate _____ Date of last physical exam _____
Are you presently under a physician's care for any condition? ❑ Yes ❑ No
If yes, please state condition _____ Name of physician _____
What is the reason for today's visit? _____

SYMPTOMS (Check [✓] symptoms you currently have or have had in the past year)

CONSTITUTIONAL
- ❑ Chills
- ❑ Fainting
- ❑ Fever
- ❑ Loss of sleep
- ❑ Loss of weight
- ❑ Nervousness
- ❑ Sweats

EARS, NOSE, THROAT, MOUTH
- ❑ Bleeding gums
- ❑ Difficulty swallowing
- ❑ Earache
- ❑ Ear discharge
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Ringing in ears
- ❑ Sinus problems

EYES
- ❑ Pain
- ❑ Blurred vision
- ❑ Crossed eyes
- ❑ Double vision
- ❑ Redness
- ❑ Visual flashes/halos
- ❑ Watering

ALLERGIC/IMMUNOLOGIC
- ❑ Hay fever

HEMATOLOGIC
- ❑ Bleeding disorders

SKIN
- ❑ Bruise easily
- ❑ Change in moles
- ❑ Hives
- ❑ Itching
- ❑ Jaundice
- ❑ Rash
- ❑ Scars
- ❑ Sore won't heal

CARDIOVASCULAR
- ❑ Chest pain
- ❑ Irregular heart beat
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles
- ❑ Varicose veins

NEUROLOGICAL
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Headache
- ❑ Loss of consciousness
- ❑ Numbness location _____
- ❑ Shaking

GENITO-URINARY
- ❑ Blood in urine
- ❑ Frequent urination
- ❑ Lack of bladder control
- ❑ Painful urination
- ❑ Urgency

ENDOCRINE
- ❑ Cold intolerance
- ❑ Goiter
- ❑ Growth changes

RESPIRATORY
- ❑ Asthma
- ❑ Coughing up blood
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Wheezing

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ❑ Arms ❑ Hips
- ❑ Back ❑ Legs
- ❑ Feet ❑ Neck
- ❑ Hands ❑ Shoulders
- ❑ Fracture _____

GASTROINTESTINAL
- ❑ Appetite poor
- ❑ Bloating
- ❑ Bowel habit changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Excessive hunger
- ❑ Excessive thirst
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Rectal bleeding
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Vomiting blood

OTHER (Please list):
_____
_____
_____
_____
_____
_____

CONDITIONS (Check [✓] conditions you currently have or have had in the past year)

- ❑ AIDS
- ❑ Alcoholism
- ❑ Anemia
- ❑ Angina
- ❑ Anorexia
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Blood clots
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chem. dependency
- ❑ Diabetes **Hgb A1C**_____
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gonorrhea
- ❑ Gout
- ❑ Heart Disease
- ❑ Headaches
- ❑ Hernia
- ❑ Herpes
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ HIV positive
- ❑ Irregular periods
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Migraines
- ❑ Miscarriage
- ❑ Multiple sclerosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostatitis
- ❑ Psychiatric care
- ❑ Rheumatic fever
- ❑ Sexually transmitted disease
- ❑ Stroke
- ❑ Suicide attempt
- ❑ Thyroid problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other (list):

_____
_____
_____
_____
_____
_____

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EYE MEDICAL HISTORY (Check [✓] conditions you have. If yes, please describe how long you have had the condition, how it affects you, and past treatments or surgeries.)

	Cataract		Macular Degeneration
	Glaucoma		Eye Surgery
	Retinal Detachment		Vision Corrective Surgery (example: Lasik, RK, PRK)
	Diabetic Eye Disease		Tearing Problem
	Strabismus (Lazy Eye)		Other:

FAMILY HISTORY (Check [✓] if your blood relatives had any of the following:)

✓	Disease	Relationship	✓	Disease	Relationship
	Arthritis, Gout			Diabetes	
	Glaucoma			High blood pressure; stroke	
	Cancer, type _____			Heart disease	
	Macular Degeneration			Other eye diseases	

HEALTH HABITS
(Check [✓] which substances you use and describe how much you use and/or how often habit is engaged in)

	Drugs			Alcohol	
	Tobacco				

What is your occupation?_____

MEDICATIONS List medications you are currently taking (include dosage)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Pharmacy Name:_____ **Phone Number:** _____

ALLERGIES or ADVERSE REACTIONS TO MEDICATIONS OR SUBSTANCES

1.	3.
2.	4.

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Time	Date	Patient, Parent or Legal Representative Signature/Relationship to Patient
Time	Date	Signature of Physician/Nurse Practitioner
Time	Date	Signature of Physician/Nurse Practitioner