SJ Vision, P.A. Patient Information

Patient History		
Name:	Age:	Today's Date
If minor, guardian name:	Date of Birth:	Sex (Male or Female)
Address:	City:	State: / Zip:
Home Phone:	Cell Phone:	E mail:
Occupation:	Employer or School:	Work Phone:

General Medical History	
Primary Care Physician Name:	Date of Last Physical:
Please list all Medications you are currently taking (in the lines below):	
Please list any allergies to medications:	
Do you currently drink? ☐ Yes ☐ No	Do you currently smoke? ☐ Yes ☐ No
Are you currently pregnant? ☐ Yes ☐No	Are you currently breastfeeding? ☐ Yes ☐No

Eye Health History	
Date of last eye exam:	Dr.'s name:
Have you ever had eye surgery or injury? ☐ Yes ☐No If yes, please explain:	

Have you ever been diagnosed with any of the following conditions?

Condition	**NO**	**YES**	**Condition**	**NO**	**YES**
Cataract			Redness		
Macular Degeneration			Burning		
Glaucoma			Itching		
Diabetes			Tearing		
Diabetic Retinopathy			Discharge		
Dry Eye					
Eye infection, inflammation or allergy					
Floaters and/or flashes					
Iritis or Uveitis					
Retinal defects or degenerations					

Family History

Please indicate their relation to YOU in the space provided. (Father, Mother, Brother, Sister, Son, or Daughter)

Cancer		Cataracts	
Diabetes Type I		Macular Degeneration	
Diabetes Type II		Glaucoma	
Hypertension		Retinal Detachment	
Hyperthyroidism			
Hypothyroidism			

Please turn page over to finish

Review of System			
Please circle all that apply to you:			
General	**Respiratory**	**Muscular/Skeletal**	**Hematology/Lymph**
Cancer _____________	Cigarette Smoker	Osteoarthritis	Anemia
	Asthma	Arthritis	High Cholesterol
Neurology	Bronchitis	Fibromyalgia	
Multiple Sclerosis	Emphysema	Osteoporosis	**Allergy/Immunology**
Epilepsy	COPD		Rheumatoid Arthritis
Cerebral Palsy	Sleep Apnea	**Skin/Integument**	Lupus
Tumors______________		Psoriasis	Sjogren's Syndrome
Migraines	**Gastrointestinal**	Rosacea	
Autism Spectrum Disorder	Chrohn's	Herpes Simplex/Cold Sores	
	Colitis	Herpes Zoster/Shingles	
Cardiovascular	Ulcer		
Hypertension		**Endocrine**	
Stroke/CVA	**GYN/Urinary**	Diabetes: Type 1 Type 2	
Heart Disease	Kidney Disease	Thyroid Dysfunction	
Vascular Disease	Prostate Disease		
Congestive Heart Failure	STD		
	Chlamydia		

Do you currently have a fever or symptoms of a respiratory infection, such as a cough or sore throat?

☐ Yes ☐ No

Have you had Covid 19 or any contact with someone known, suspected COVID-19/Coronavirus OR with an immediate family member who has exhibited signs and symptoms of fever and/or respiratory infection such as a cough or sore throat within the last four weeks ?

☐ Yes ☐ NO

If you answered "yes" to any of the above questions, please return this to our technician.