Name:_____ Date:_____

PCP:_____ Referred by:_____

GENSTLER EYE CENTER
2700 14th Ave. SE
Albany, OR 97322

Hearing Ability

	Poor			Some Loss					Excellent
Rate **your** overall **hearing** ability:	1	2	3	4	5	6	7	8	9	10
Your **hearing** ability rated by your family:	1	2	3	4	5	6	7	8	9	10

Review of Body Systems

☐ No body systems problems

Constitutional (General Health):
- ☐ **No problems**
- ❍ fever
- ❍ _____

Head, Eyes, Ears, Nose. Throat:
- ☐ **No problems**
- ❍ hearing loss
- ❍ _____

Lungs:
- ☐ **No problems**
- ❍ asthma
- ❍ cough (chronic)
- ❍ _____

Heart:
- ☐ **No problems**
- ❍ chest pressure / pain
- ❍ irregular heartbeat
- ❍ _____

Stomach / GI:
- ☐ **No problems**
- ❍ nausea
- ❍ vomiting
- ❍ _____

Urinary System:
- ☐ **No problems**
- ❍ _____
- ❍ _____

Glands:
- ☐ **No problems**
- ❍ cold intolerance
- ❍ heat intolerance
- ❍ _____

Brain / Nerves:
- ☐ **No problems**
- ❍ dizziness
- ❍ chronic headache
- ❍ _____

Psychiatric:
- ☐ **No problems**
- ❍ emotional changes
- ❍ _____

Skin:
- ☐ **No problems**
- ❍ rash
- ❍ _____

Muscles / Bones:
- ☐ **No problems**
- ❍ joint swelling
- ❍ muscle weakness
- ❍ _____

Blood / Lymphatic:
- ☐ **No problems**
- ❍ bleeding problems
- ❍ _____

Allergy / Immunologic:
- ☐ **No problems**
- ❍ seasonal allergies
- ❍ _____

Current Medications:

☐ **None**

_____

_____

_____

_____

_____

_____

_____

_____

Medication Allergies:

☐ **None**

Reaction

_____

_____

_____

Latex Allergy:

☐ No ☐ Yes

Tobacco Use:

Have you ever used tobacco?

- ☐ Current **every day** smoker
- ☐ Current **occasional** smoker
- ☐ **Never** a smoker
- ☐ **Former** smoker

Genstler Eye Center encourages patients to **stop smoking** since smoking can increase the risk of eye disease and cause other eye complications.

Turn page over & complete back page

Back Page

Eye Medical History

☐ **No eye problems**

	Eye	
☐ Amblyopia (lazy eye)	R	L
☐ Cataracts	R	L
☐ Glaucoma	R	L
☐ Retinal Detachment	R	L
☐ Macular Degeneration	R	L

Eye Surgery History

☐ **None**

☐ **Surgery done at Genstler Eye Center**

Right Eye	Year	**Left Eye**	Year
☐ Cataract		☐ Cataract	
☐ LASIK		☐ LASIK	
☐ RK		☐ RK	
☐ Glaucoma		☐ Glaucoma	
☐ _____		☐ _____	
☐ _____		☐ _____	

Medical History
(Please check condition as applies to you)

☐ **No Previous History**

☐ Asthma

☐ Arthritis
- ☐ rheumatoid arthritis
- ☐ juvenile arthritis
- ☐ ankylosing spondylitis

☐ Atrial fibrillation

☐ Cardiac arrhythmia

☐ COPD

☐ Diabetes, **juvenile** on insulin

☐ Diabetes, **adult** treated with
- ☐ diet
- ☐ pills
- ☐ insulin

☐ Heart disease

☐ High blood pressure

☐ High cholesterol

☐ Lupus

☐ Thyroid disease

☐ _____

☐ _____

☐ _____

Surgical History (other than eye surgery)

☐ **None** Year

(Only list surgeries in past 3 years)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Family Eye and Medical History

Father

☐ **None** ☐ **Unknown**

☐ Lazy eye / Amblyopia

☐ Glaucoma

☐ Macular degeneration

☐ Diabetes, **juvenile** on insulin

☐ Diabetes, **adult** treated w
- ☐ diet
- ☐ pills
- ☐ insulin

☐ _____

☐ _____

☐ _____

☐ _____

Mother

☐ **None** ☐ **Unknown**

☐ Lazy eye / Amblyopia

☐ Glaucoma

☐ Macular degeneration

☐ Diabetes, **juvenile** on insulin

☐ Diabetes, **adult** treated w
- ☐ diet
- ☐ pills
- ☐ insulin

☐ _____

☐ _____

☐ _____

☐ _____

☐ Brother ☐ Sister

☐ **None** ☐ **Unknown**

☐ Lazy eye / Amblyopia

☐ Glaucoma

☐ Macular degeneration

☐ Diabetes, **juvenile** on insulin

☐ Diabetes, **adult** treated w
- ☐ diet
- ☐ pills
- ☐ insulin

☐ _____

☐ _____

☐ _____

☐ _____

Thank you!