THE EYE & VISION CENTER
MCPHS UNIVERSITY

10 LINCOLN SQUARE
WORCESTER MA 01608
P: 508-373-5830 F: 508-519-5512

Name: _____ Date: _____/_____/_____
Preferred Name: _____ DOB: _____/_____/_____
Preferred Pronoun: His/Him She/Her They/Them Other:_____ Age: _____
Address: _____ Sex at Birth: M / F
Preferred Phone# _____ Gender: _____

Name of Primary Care Physician: _____ Last Medical Exam: _____
Primary Care Physician Address: _____
Pharmacy Name/Location/Phone: _____

What is the reason for today's exam? Please circle appropriate response: Y = Yes N = No

Y / N	Blur	Y / N	Red Eyes	Y / N	Headache	Y / N	Broken glasses
Y / N	Vision Loss	Y / N	Discharge	Y / N	Flashes	Other: _____	
Y / N	Computer Strain	Y / N	Eye Pain	Y / N	Floaters		
Y / N	Dry Eye	Y / N	Itching	Y / N	Double Vision		

Eye History:

Last Eye Exam: _____ Doctor's Name & Location? _____
Do you currently wear glasses? Y / N How old are your current glasses? _____
Do you currently wear contact lenses? Y / N

Do you have or have you ever been treated for any of the following?

Y / N	Glaucoma	Y / N	Cataracts	Y / N	Retinal Disease
Y / N	Macular Degeneration	Y / N	Lazy Eye		
Y / N	Eye Turn	Y / N	Retinal Detachment		

Y / N Have you had an eye injury? If yes, explain _____
Y / N Have you had any eye surgeries? If yes, explain _____
Y / N Have you had vision therapy? If yes, explain _____
Y / N Do you take eye medications? If yes, which ones? _____

Medical History:

Do you have or have you ever been treated for?

Y / N	Diabetes	Y / N	Thyroid Disease	Y / N	Hepatitis
Y / N	High Blood Pressure	Y / N	Neurological/Headaches	Y / N	Sinus/Allergy
Y / N	High Cholesterol	Y / N	Tuberculosis	Y / N	Immunocompromised
Y / N	Heart disease	Y / N	Cancer	Other: _____	
Y / N	Breathing problems	Y / N	Blood disorders		
Y / N	Arthritis/ joint pain	Y / N	HIV		

Do you have an active cough or fever? Y / N

Are you pregnant or nursing? Y / N

Please list all prescribed and over the counter medications and vitamins you take:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any allergies to medications? Y / N
If yes, list allergen and reaction: _____

REVIEW OF SYSTEMS: Are you <u>currently</u> experiencing any of the following?
Please circle all that apply:

Fever	Diarrhea	Skin color changes	Mood changes
Fatigue	Nausea	Joint pain or stiffness	Memory changes
Weight loss/gain	Abdominal pain	Joint weakness	Hearing loss
Chills	Genital lesions	Paralysis	Sore throat
Heat/Cold Intolerance	Frequent urination	Numbness	Hair loss
Chest pains	Pain with urination	Headaches	Menstrual changes
Palpitations	Blood in urine	Seizures	Excessive thirst
Shortness of breath	Rashes	Tremors	Excessive hunger
Wheezing	Excessive dryness of Skin	Dizziness	Excessive bruising
Heartburn	Lumps or growths of Skin	Depression	Swollen glands or nodes
Constipation	Itching	Anxiety	Blood clots

<u>Family Medical/ Ocular History:</u>

Have any of your immediate family members ever been treated for?

Y / N	Diabetes	Y / N	Thyroid	Y / N	Lazy Eye
Y / N	High Blood Pressure	Y / N	Retinal Disease	Y / N	Eye Turn
Y / N	Heart Disease	Y / N	Blindness	Other: _____	
Y / N	High Cholesterol	Y / N	Glaucoma		
Y / N	Cancer	Y / N	Macular degeneration		