T&KEI

TERRY & KIM EYE INSTITUTE

Advancing Eye Care with Research and Compassion

MRN # _____

Please fill out this demographic information so that we may assist you in the best way possible, thank you.

Name _____ **DOB** _____

Email _____ **Date** _____

Pharmacy _____ **Pharmacy City** _____

Pharmacy Address _____

Who is your primary care doctor _____

Would you like to be contacted by PHONE CALL, EMAIL or TEXT MESSAGE as a reminder for your upcoming appointments:

_____

Past Medical History (check all that apply) :

- ☐ **Anxiety**
- ☐ **Arthritis**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Atrial Fibrillation**
- ☐ **Blood Pressure**
- ☐ **Bone Marrow**
- ☐ **Breast Cancer**
- ☐ **Colon Cancer**
- ☐ **COPD**
- ☐ **Coronary Artery Disease**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **End Stage Renal**
- ☐ **GERD**
- ☐ **Hearing Loss**
- ☐ **Hepatitis**
- ☐ **Hypertension**
- ☐ **HIV/AIDS**
- ☐ **Hypercholesterolemia**
- ☐ **Hypothyroidism**
- ☐ **Hyperthyroidism**
- ☐ **Leukemia**
- ☐ **Lung Cancer**
- ☐ **Lymphoma**
- ☐ **Multiple Sclerosis**
- ☐ **Pacemaker**
- ☐ **Prostate Cancer**
- ☐ **Radiation Therapy Treatment**
- ☐ **Stroke**
- ☐ **Valve Replacement**
- ☐ **None**

☐ **Other :** _____

Past Surgical History (please check all that apply) :

- ☐ **Appendix Removed**
- ☐ **Bladder Removed**
- ☐ **Mastectomy (Right, Left)**
- ☐ **Colectomy**
- ☐ **Gallbladder Removed**
- ☐ **Coronary Artery Bypass**
- ☐ **PTCA**
- ☐ **Valve Replacement**
- ☐ **Heart Transplant**
- ☐ **Joint Replacement (Hip, Knee)**
- ☐ **Kidney Removal (Right, Left)**
- ☐ **Kidney Transplant**
- ☐ **Ovaries Removed**
- ☐ **Prostate Removed**
- ☐ **TURP**
- ☐ **Basal Cell Cancer Surgery**
- ☐ **Squamous Cell Carcinoma Surgery**
- ☐ **Melanoma Surgery**
- ☐ **Hysterectomy**
- ☐ **None**

☐ **Other** _____

Ocular History:

- ☐ Allergic Conjunctivitis
- ☐ Blepharitis
- ☐ Cataract (R, L)
- ☐ Diabetic retinopathy (R, L)
- ☐ Dry Eyes (R, L)
- ☐ Glaucoma (R, L)
- ☐ Macular degeneration (R, L)
- ☐ Vitreous floaters (R, L)
- ☐ Epiretinal membrane (R, L)
- ☐ Narrow angles (R, L)
- ☐ Ocular HTN (R, L)
- ☐ Opthalmic migraine
- ☐ Pseudoexfoliation
- ☐ Retinal tear (R, L)
- ☐ Strabismus
- ☐ PVD (R, L)
- ☐ None

☐ Other : _____

Ocular Surgery :

- ☐ Blepharoplasty
- ☐ Cataract (R, L)
- ☐ Corneal Transplant (R, L)
- ☐ DSEK (R, L)
- ☐ Intravitreal Injection (R, L)
- ☐ Trabeculectomy (R, L)
- ☐ LPI (R, L)
- ☐ PRK (R, L)
- ☐ Ptosis Repair (R, L)
- ☐ Punctal Plugs (R, L)
- ☐ Strabismus surgery
- ☐ Retinal Laser (R, L)
- ☐ LASIK (R, L)
- ☐ YAG Laser (R, L)
- ☐ None

☐ Other : _____

Medication :

_____

_____

_____

_____

_____

☐ None

Allergies :

_____

_____

_____

_____

☐ None

Social History:

Cigarrette Smoking:

- ☐ **Never Smoked**
- ☐ **Quit: Former Smoker**
- ☐ **Smokes Less Than Daily**
- ☐ **Smokes Daily**

Illicit Drug Use:

- ☐ **Drug Use :**
- ☐ **IV Drug Use / IV**
- ☐ **None**

Alcohol Use

- ☐ **Less Than 1 Drink A Day**
- ☐ **1-2 Drink A Day**
- ☐ **3 Or More Drinks A Day**
- ☐ **None**

- ☐ **Other : _____**

Family History:

Blindness _____

Cancer _____

Cataracts _____

CVA _____

Diabetes _____

Glaucoma _____

Heart Disease _____

Macular Degeneration _____

Migraine _____

Retinal Detachment_____

Strabismus _____

None

Other : _____

Please describe what is bringing you in to see us today?

Decreased vision at (near, far) (right eye, left eye)? How long?

_____

_____

Eye Discomfort (red, foreign body sensation, tearing) (right eye, left eye) How long?

_____

_____

Other :

_____

_____

_____