TODAY'S DATE: _____

Scott Bailey, O.D.

5919 Harbour Park Drive • Midlothian, Virginia 23112
Phone: 804-739-8646 • Fax: 804-739-9651

Age _____

Patient Name: First _____ MI _____ Last _____ Date of Birth ___/___/___

Address _____ City _____ State _____ Zip Code _____

Primary Care Physician / Referring Doctor _____ Phone # _____

Current Medications _____

Known Allergies (medications or other) _____

Previous Eye Injury / Surgery / Laser Treatment _____ Last Eye Exam ___/___/___

HEALTH HISTORY - Do you now or have you ever had any of the following? PLEASE MARK ACCORDINGLY BY CIRCLING.

EYES

Glaucoma	No	Yes
Cataracts	Now	Past
Macular Disease	Now	Yes
Retinal Disease / Disorder	No	Yes
Loss of Vision	Now	Past
Blurred Vision	Now	Past
Double Vision	Now	Past
Loss of Side Vision	Now	Past
Visual Halos / Glare	Now	Past
Flashers / Floaters	Now	Past
Chronic Eye Pain	Now	Past
Dry or Gritty Eyes	Now	Past
Redness / Discharge	Now	Past
Itching / Burning	Now	Past
Excessive Tearing	Now	Past
Lid Infection / Disorder	Now	Past
Eye Strain / Fatigue	Now	Past
Lazy Eye	Now	Past

Other _____

GENERAL HEALTH

Pregnant / Nursing	No	Yes
Sudden Weight Changes	No	Yes
Chronic Fatigue	No	Yes

PSYCHIATRIC

Anxiety / Depression	No	Yes

Other _____

EARS / NOSE / THROAT

Sinus Conditions	No	Yes
Dry Mouth / Throat	No	Yes
Chronic Cough	No	Yes

ALLERGIC / IMMUNOLOGIC

Systemic Lupus	No	Yes
Sarcoid	No	Yes
Sjogrens	No	Yes
Allergies / Hayfever	No	Yes

Other _____

CARDIOVASCULAR

Heart Disease / Atherosclerosis	No	Yes
Hypertension / High Blood Pressure	No	Yes

RESPIRATORY

Asthma	No	Yes
Emphysema	No	Yes

GASTROINTESTINAL

Acid Reflux	No	Yes

Other _____

URINARY

Kidney Disease	No	Yes
Prostate Condition	No	Yes

MUSCULOSKELETAL

Chronic Arthritis	No	Yes
Juvenile Arthritis	No	Yes
Rheumatoid Arthritis	No	Yes
Lyme Disease	No	Yes

Other _____

SKIN

Acne / Rash / Eczema	No	Yes
Skin Cancer	No	Yes

Other _____

NEUROLOGICAL

Headaches / Migraines	No	Yes
Multiple Sclerosis	No	Yes

Other _____

ENDOCRINE

Diabetes	No	Yes
Thyroid Disease	No	Yes
Graves Disease	No	Yes

Other _____

BLOOD / LYMPH

Anemia	No	Yes
Sickle Cell	No	Yes
Bleeding Disorder	No	Yes
Hepatitis (Type) _____	No	Yes
HIV / AIDS	No	Yes

Other _____

***FAMILY MEDICAL / OCULAR HISTORY** - Please list any known family history: Health and Ocular diseases (diabetes, glaucoma, etc.)

Parents _____ Grandparents _____ Siblings _____

SOCIAL HISTORY: Please complete below by circling correct response

Use of Alcohol: Never Previously, but quit Rarely Regularly (on a weekly basis, how much) _____

Use of Tobacco: Never Previously, but quit Rarely Regularly (on a weekly basis, how much) _____

Use of Illegal Drugs: Never Previously, but quit Current Use Type / Frequency _____

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