AcuSight

Dr. Rachel Siegel

Patient name:_____ Date of birth: _____ Age: _____

What is the main reason for your visit today? _____

Personal Eye Problems

Are you having any (circle): Redness / Burning / Itching / Tearing / Discharge

Have you had any (circle): Cataracts / Macular Degeneration / Glaucoma / Diabetes / Dryness / Infection
Floaters or Flashes / Iritis or Uveitis/ Retinal Defects

Personal Health

Do you have or have you ever had any problems in the following areas? (Please circle)

- **Constitutional:** Developmental Disabilities / Cancer / Fatigue Syndrome
- **Ears, Nose, Throat:** Hearing Loss / Sinusitis / Dry Throat, Mouth / Laryngitis
- **Neurological:** MS / Epilepsy / Cerebral Palsy / Tumor / Stroke, CVA / Migraines / Autism Spectrum
- **Psychiatric:** Depression / Attention Deficit / Anxiety / Bipolar Disorder
- **Cardiovascular:** High Blood Pressure / Stroke / Heart, Vascular Disease / Congestive Heart Failure
- **Respiratory:** Smoker / Asthma / Bronchitis / Emphysema / Chronic Obstruction / Sleep Apnea
- **Gastrointestinal:** Crohn's / Colitis / Ulcer / Acid Reflux / Celiac Disease
- **Genitourinary:** Kidney / Prostate Cancer / STD / Benign Prostate Hyperplasia / Pregnant / Nursing
- **Muscles/Skeletal:** Osteo-Arthritis / Rheumatoid Arthritis / Fibromyalgia / Muscular Dystrophy
  Ankylosing Spondylitis / Osteoporosis / Gout
- **Integumentary:** Eczema / Rosacea / Psoriasis / Herpes Simplex, Skin Lesions / Herpes Zoster, Shingles
- **Endocrine:** Diabetes Type II, Type I / Thyroid / Hormone Dysfunctions
- **Lymphatic/Hematologic:** Anemia / History of Large Blood Loss / Ulcer / Cholesterol
- **Allergic/Immunologic:** Allergies / Rheumatoid Arthritis / Lupus / Sjogren's Syndrome
- **Other:** _____

Please list current medications and dosages: _____

Please list any allergies (including drugs and environment):_____

Please list any previously diagnosed eye diseases:_____

Please list any previous eye surgeries: _____

Do you use any of the following products? **Alcohol:** No / Yes **Tobacco:** No / Yes

Amount:_____ _____

Family History:

Has anyone in your family been treated for: If not, check here_____

Diabetes:	Mother / Father	Brother / Sister	Son / Daughter
High Blood Pressure:	Mother / Father	Brother / Sister	Son / Daughter
Cancer:	Mother / Father	Brother / Sister	Son / Daughter
Hypo –Thyroid:	Mother / Father	Brother / Sister	Son / Daughter
Hyper-Thyroid:	Mother / Father	Brother / Sister	Son / Daughter
Cataracts:	Mother / Father	Brother / Sister	Son / Daughter
Macular Degeneration:	Mother / Father	Brother / Sister	Son / Daughter
Glaucoma:	Mother / Father	Brother / Sister	Son / Daughter