Joseph Fife, O.D.
Paradise Canyon Eye Care
1449 N 1400 Ste. 24
St George, UT 84770
Phone: 435.656.2003
www.paradiseeye.com

Patient Information

Date_____________ Patient's Name (please print) ____

Spouse's Name ____ **if a child, name of parent or guardian** ____

Street Address____

City___________________________________ State ___________________ Zip________________________

Home Phone________________ Cell Phone__________________ Work Phone _____________________

E-Mail ______________________ Date of Birth _________________ M or F SSN _________________

Occupation_________________ Employer ___________________ Spouse's Employer _______________

If you are a new patient, how did you hear about our office? __________________________________

Medical History

Do you have difficulties with any of the following systems?

- ❑ Hypertension
- ❑ Thyroid
- ❑ Cardiovascular
- ❑ Cancer
- ❑ Diabetes
- ❑ Cardiovascular
- ❑ Musculoskeletal
- ❑ Endocrine (Glands)
- ❑ Respiratory
- ❑ Skin
- ❑ Allergic/ Immunologic
- ❑ Blood/Lymph

Please list the date and type of surgeries you have had:

____

____

Are you in good general health? Yes ___ No ___

Weight (lbs) ______ Height (in) ______ Height (ft) _____

Are you pregnant or nursing? _______________

Do you have any allergies to medications or other substances? Yes __ No __
If yes, please list ____

Name and phone number of your Primary Care Physician?

____

List **ALL** major injuries or surgeries you have had and approximate dates:

____

List any other medical conditions you have had, including non-drug allergies:

____

List all RX and over-the-counter medications you currently take:

____

List any vitamins or supplements you currently take:

____

List any drug allergies you have:

____

Smoking Status — Yes __ No __ How much? _______________Per_________________
Alcohol Use — Yes __ No __ How much? _______________Per_________________
Do you live alone? — Yes ___ No ___ Assisted Living ____Nursing Home ______

Current medications: (**Please list names and how often**) ____

____

Do you or any of your relatives have a history of any of the following?

- ❑ High Blood Pressure
  Relation: ______________
- ❑ Macular Degeneration
  Relation: ______________
- ❑ Diabetes
  Relation: ______________
- ❑ Retinal Detachment *Relation:*______________
- ❑ Glaucoma
  Relation: ______________
- ❑ Cataracts
  Relation: ______________

Do you have any of the following?

- ❑ Dry Eyes
- ❑ Eye Surgeries
- ❑ Wear Contacts/Glasses
- ❑ Blurred vision
- ❑ Eye Injuries
- ❑ Itchy Eyes

Review of Systems

Please list any problems that you are currently having anywhere, from head to toe:

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain)

____

Ear, Nose, Throat (e.g., sinus/nasal congestion, nose bleeds, dry mouth/throat, sleep apnea, hearing problems)

____

Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, TIAs)

____

Respiratory (e.g., chronic cough, shortness of breath, wheezing)

____

Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, discharge, menstrual changes, impotence)

____

Gastrointestinal (e.g., constipation, diarrhea, gastric reflux (GERD), jaundice, nausea, vomiting)

____

Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination)

____

Muscles, Bones, Joints (e.g., pain, stiffness, swelling, weakness, limited movements)

____

Skin (e.g., dry, itchy, flaky, rash, growths, bumps, redness, discoloration)

____

Neurological (e.g., headaches, numbness/tingling, tremors, poor balance, dementia, speech problems)

____

Psychiatric (e.g., depression, anxiety, sleep problems, paranoia, obsessive/compulsive)

____

Blood/Lymph (e.g., anemia, bleeding gums, delayed clotting, unexplained bruising)

____

Allergy/Immune (e.g., swollen lymph nodes, itching, sneezing, runny nose/eyes)

____

Ocular History

Who was your previous eye doctor? ____

When was your last eye exam? ____

Check the box for any conditions that apply:

	You	Mom	Dad	Sib	Describe (type, when diagnosed, which eye (s), treatment, etc.)
Glaucoma	___	___	___	___	____________________
Macular Degeneration	___	___	___	___	____________________
Retinal Problems	___	___	___	___	____________________
Cataracts	___	___	___	___	____________________
Lazy Eye/Eye Turn	___	___	___	___	____________________

List any major eye injuries, infections or surgeries and approx. dates:

____

List any other significant eye problems you have had:

____

List all RX and over-the-counter eye medications you currently use:

____

List any vision complaints you are currently having such as:

Blurred vision, headaches, eyestrain, double vision, or losing your place when reading.
Itching, burning, redness, pain sensitivity to light, watering, crusting or mucus discharge.
Seeing rainbows around white lights at night, flashes of light or dark spots/squiggles/webs.

____

How many hours/day do you typically spend using a computer or other digital devices? ____________________

If you are having complaints with computer work, how far is the monitor from your eyes? ____________________

How many hours/day do you typically spend reading books, magazines, etc.? ________________________________

What are your hobbies/sports activities? ____

Do you have sunglasses? ____

Do you have back-up glasses? ____

Are you interested in contacts? ____

Contact Lens Wearers Only

What disinfecting solution do you use? ____

How long do you usually wear your lenses? ____

How often do you replace your lenses? ____

How old is your current pair of contacts? ____

I certify that the information I have provided is complete and accurate to the best of my knowledge.

Signature____ **Date** _______________________

Relation____

Thank you!

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