Emerald EyeCare LLC
...uniquely you

Dr. Jonathan Culp
Dr. Michelle Denny
Dr. Stephen Denny
Dr. Susan Wright

Patient Name: _____ Date of Birth: _____

Social Security Number: _____Employer/School: _____Position:_____

Preferred email address: _____

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
- Psychiatric: Depression, Attention Deficit, Anxiety, Bipolar Disorder
- Cardiovascular: High Blood Pressure, Stroke, Heart Disease, Congestive Heart Failure
- Respiratory: Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apnea
- Gastrointestinal: Crohn's Disease, Colitis, Ulcer, Acid Reflux, Celiac Disease
- Genitourinary: Kidney disease, Prostate cancer, STD-Herpetic or Chlamydia, Benign Prostate Hypertrophy, Currently Pregnant or Nursing
- Muscles/Skeletal: Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout
- Integumentary: Eczema, Acne Rosacea, Psoriasis, Cold sores, Shingles
- Endocrine: Diabetes Type I or Type II, Thyroid Dysfunction, Hormone Dysfunctions
- Lymphatic/Hematologic: Anemia, History of Large Blood Loss, Ulcer, High Cholesterol
- Allergic/Immunologic: Allergies (Medication or Environment or Latex), Rheumatoid Arthritis, Lupus, Sjogren's Syndrome

List current Medications/vitamins/supplements and dosages: _____

_____

List any Allergies (Medication or Environment): _____

List any previously diagnosed Eye Diseases: _____

Do you use any of the following products?

Alcohol	Yes	No	Amount: _____	per day/ week/ month
Tobacco	Yes	No	Amount:_____	per day/week/ month

Family History: (please circle)

Cataracts:	Father	Mother	Brother	Sister	Son	Daughter
Macular Degeneration:	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma:	Father	Mother	Brother	Sister	Son	Daughter
Cancer:	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type I or II (circle type):	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure:	Father	Mother	Brother	Sister	Son	Daughter
Overactive/ Hyperthyroid:	Father	Mother	Brother	Sister	Son	Daughter
Underactive/ Hypothyroid:	Father	Mother	Brother	Sister	Son	Daughter