General Information Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: ( ) _____

Whom may we thank for referring you? _____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/___ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type:_____ Solution Used: _____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly Yearly**

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms: Please circle any that apply:

[ ] Blurred Vision/Distance
[ ] Blurred Vision/Near
[ ] Double Vision
[ ] Eye Strain
[ ] Eye Infections
[ ] Eye Pain/Soreness
[ ] Tired eyes
[ ] Burning Eyes
[ ] Itchy Eyes
[ ] Dry Eyes
[ ] Red Eyes
[ ] Watery Eyes
[ ] Wandering eye
[ ] Mucus Discharge
[ ] Floaters or Spots
[ ] See Flashes
[ ] See Halos
[ ] Poor Night Vision
[ ] Headaches
[ ] Migraine Headaches
[ ] Loss of Vision
[ ] Crossed Eyes
[ ] Light Sensitive
[ ] Sandy/Gritty Feeling
[ ] Poor Color Vision
[ ] Droopy Lid

Please turn over and complete other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ None ___ Hypertension ___ Stroke ____ High Cholesterol ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** __ None ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ None ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** __ None ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies** (please list) __ None Drug: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list physical reaction's to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal) :

1	**For**	**2**	**For**
3	**For**	**4**	**For**
5	**For**	**6**	**For**
7	**For**	**8**	**For**
9	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION

Retinal Detachment:	Yes/No _____	Blindness:	Yes/No _____
High Blood Pressure:	Yes/No _____	Cataracts:	Yes/No _____
Diabetes:	Yes/No _____	Glaucoma:	Yes/No _____
Cancer:	Yes/No _____	Crossed Eyes:	Yes/No _____
Heart Disease:	Yes/No _____	Macular Degeneration:	Yes/No _____
Thyroid Disease:	Yes/No _____	Lupus	Yes/No _____

Reviewed by:

Dr _____ Date _____

Vision Needs Checklist

Patient Name: _____ Date: _____

1. Are you generally satisfied with the eyeglasses you're now wearing?

Yes ___ No___

2. Do you experience any *eye strain* under the following conditions?

Please check all that apply:

__ Artificial/Fluorescent Lighting
__ Reading
__ Computer Work
__ Paperwork
__ Car Headlights
__ Hazy Conditions
__ Night Driving
__ Bright Sunshine
__ Snow
__ Other _____

3. In what *Recreational Activities* do you participate?

Please check all that apply:

__ Swimming/Diving
__ Golf
__ Cycling
__ Hunting/Shooting
__ Driving
__ Jogging/Running
__ Skiing/Snowboarding
__ Boating/Fishing
__ Other _____

4. In what *Sports Activities* do you participate?

Please check all that apply:

__ Basketball
__ Soccer
__ Baseball
__ Tennis

5. Are you involved in an *Occupation* where there is potential risk to eye health such as:

__ Auto Repair
__ Landscaping
__ Painting/Carpentry
__ Health Care
__ Utilities
__ Electrical
__ Construction
__ Other _____

6. Are there specific products you've become aware of since your last visit that you'd like to learn more about?

Please list: _____

_____

_____