

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:

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

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 <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke ___ High Cholesterol <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	Endocrine: __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	Respiratory: __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
Constitutional: __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	Ocular __ None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	Psychiatric: __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
Neurological: __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	Musculoskeletal: __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	Immunologic: __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
Hematological: __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	Gastrointestinal __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	Ear/Nose/Throat: __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
Dermatologic: __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> 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 _____