WELCOME

Please take time to fill out this form. It will help us provide the best care for your vision and eye health.

Mr.-Mrs.-Ms.-Dr. _____

Street _____

City _____ State _____ Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email Address _____

Occupation or Grade of Patient _____

What is the major reason for your exam today? _____

_____

MEDICAL REVIEW OF SYSTEMS*: (Circle all that apply)*

Const. none / fatigue / developmental disorder
ENT none / sinus / dry mouth / hearing loss
Neuro none / migraine / stroke / CVA / epilepsy / MS / CP
Psych none / anxiety / bipolar / depression / ADD
Cardio none / high blood pressure / heart disease / stroke / vascular
Resp none / sleep apnea / asthma / bronchitis / emphysema
Gastro none / celiac / colitis / acid reflux / ulcer
Gen/Ur none / nursing / pregnant / prostate / kidney / herpes / chlamydia
Musc/Skel none / arthritis / osteoporosis / fibromyalgia / muscular dystrophy
Integ none / rosacea / eczema / psoriasis / shingles / acne
Endo none / thyroid / hormonal / diabetes Type I or Type II
Hem/Lymph none / anemia / large volume blood loss / high cholesterol
Allergy / Imm none / enviro / food / drug / latex / sjogren's / lupus
OTHER: _____

CURRENT MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER)

Name	Taken For

MEDICATION ALLERGIES

LIST: _____

_____

_____

Where did you receive your last eye care? _____

Have you ever worn, or are you currently wearing contact lenses?

❒ Yes ❒ No What kind? _____ Solutions used? _____

Any problems with your present contact lenses or glasses?

❒ Yes ❒ No Explain _____

_____

What do you like about your present contact lenses or glasses?

_____

Today's Date _____ Date of Last Exam _____

Date of Birth _____ Age ____ Full Time Student ❒ Yes ❒ No

Sex: ❒ M ❒ F

Spouse (or Parents' Names) _____

Spouse (or Parents' Names) Work Phone _____

Vision Insurance _____

Primary Medical Insurance _____

Employer of Responsible Party _____

RACE: _____

ETHNICITY: ❒ Hispanic or Latino ❒ Not Hispanic or Latino

PATIENT OCULAR REVIEW

❒ eye injury	❒ macular degeneration	❒ other
❒ eye surgery	❒ glaucoma	_____
❒ laser vision correction	❒ retinal detachment	
❒ cataract	❒ lazy eye	
❒ cataract removal	❒ crossed eye	

Do you or have you had any of these?

❒ night blindness	❒ spots/floaters	❒ styes
❒ light sensitivity	❒ light flashes	❒ itching
❒ double vision	❒ headaches	❒ burning
❒ eye strain	❒ nausea	❒ redness
❒ eye pain	❒ dizziness	❒ dryness
❒ blurry vision	❒ eye twitch	❒ tearing

FAMILY MEDICAL HISTORY

			Relationship
Glaucoma	❒ No	❒ Yes	_____
Macular Degeneration	❒ No	❒ Yes	_____
Cataracts	❒ No	❒ Yes	_____
Blindness	❒ No	❒ Yes	_____
Retinal Detachment	❒ No	❒ Yes	_____
Lazy Eye	❒ No	❒ Yes	_____
Crossed Eye	❒ No	❒ Yes	_____
Diabetes	❒ No	❒ Yes	_____
High Blood Pressure	❒ No	❒ Yes	_____
Autoimmune Disease	❒ No	❒ Yes	_____
OTHER	❒ No	❒ Yes	_____

Physician's Name _____ City _____

SOCIAL HISTORY - Complete

Smoking status current / former / never

Alcohol use Yes / No How often? _____

Are you interested in purchasing glasses today? ❒ Yes ❒ No

Are you interested in Laser Vision Correction? ❒ Yes ❒ No

Are you interested in contact lenses? ❒ Yes ❒ No

Are you interested in sunglasses? ❒ Yes ❒ No

Signature _____

Office use: ROS/PFSH _____ Date _____ Init _____