

WELCOME

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

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? _____

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

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: _____

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	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Macular Degeneration	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Cataracts	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Blindness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Retinal Detachment	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Lazy Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Crossed Eye	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
Autoimmune Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____
OTHER	<input type="checkbox"/> No	<input type="checkbox"/> Yes	_____

CURRENT MEDICATIONS (PRESCRIPTION AND OVER THE COUNTER)

Name	Taken For
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS 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?

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 _____