

Welcome to Our Office!

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So that we may know you better, please take a moment to fill out this information about yourself and your history.

Name: _____ M F Date: _____
 Street Address: _____ City: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ Birthdate: _____ Age: _____
 Cell Phone: _____
 E-Mail Address: _____

Occupation: _____
 Employer: _____
 Medical Insurance: _____
 Eyecare Insurance: _____
 Social Security # _____
Whom may we thank for referring you? _____
 Please list your interests and hobbies: _____

In the last few years have you experienced:

Blurry vision Flashes of Light Sunlight sensitivity
 Burning Floaters/ Spots Excessive tearing
 Crossing eyes Eye discomfort Trouble seeing at night
 Double vision Headaches Uncomfortable glasses
 Dryness Itchiness

Date of last eye exam _____
 By whom? _____
Do you currently wear Contact Lenses? Yes No
 What type of Contact Lenses? _____
 Are you interested in changing your eye color? Yes No
 What type of Contact solution used? _____
If you wear contact lenses, are you satisfied with your vision and comfort? Yes No

Name of Family Physician _____
 Physician's Phone Number _____
 Date of Last Physical Check-Up _____

Do you (Check if your answer is YES)

...Work at a computer? _____ hours/week
 ...Think you would benefit from lighter/thinner lenses?
 ...Have interest in the latest Contact Lens Design?
 ...Spend time outdoors? _____ hours/week
 ...Have prescription sunglasses?
 ...Prefer not to wear your glasses at times?
 ...Want more information on Laser Vision Correction?
 ...Have more than 1 pair of current RX glasses?
 ...Smoke? ...Use recreational drugs including marijuana?
 ...Drink more than 2 alcoholic beverages per day?
 ...Have family members in need of eyecare?

FAMILY HISTORY

Is there any family history of the following: (list relation to you please)

Blindness _____
 Cataracts _____
 Crossed Eyes _____
 Glaucoma _____
 Lazy Eye _____
 Macular Degeneration _____
 Retinal Problems _____
 Cancer _____
 Diabetes _____
 Heart Disease _____
 High Blood Pressure _____
 Kidney Disease _____
 Thyroid Disease _____
 Other _____

PERSONAL EYE HISTORY

Have you ever been diagnosed or treated for:

Cataracts Iritis/Uveitis Strabismus/Eye turn
 Corneal Abrasion Eye Injuries Other Eye Disorders?
 Eye Infections Macular Degeneration
 Retinal Detachment Glaucoma

SURGICAL HISTORY:

Please list your major injuries, surgeries, and hospitalizations

Please Turn this Form Over and Complete Side Two

REVIEW OF SYSTEMS

Have you had current or chronic problems in the following areas:

SYSTEM	NO	YES	?	
CONSTITUTIONAL				IF YOU ANSWER YES TO THE SYSTEM QUESTIONS, or have a condition not listed, please explain and list: <div style="border: 1px solid black; height: 300px; margin-top: 5px;"></div>
High Fever, Large Weight Loss/Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
DERMATOLOGIC (SKIN)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
NEUROLOGICAL				
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Migranes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ENDOCRINE				
Thyroid/Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
EARS, NOSE, MOUTH, THROAT				
Allergies/Hay Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Runny Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Chronic Cough	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Dry Throat/Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
RESPIRATORY				
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
VASCULAR/CARDIOVASCULAR				
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Heart Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Vascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
GASTROINTESTINAL				
Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Crohn's/Diverticulitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
GENITOURINARY				
STD's/Kidney/Bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
BONES/JOINTS/MUSCLES				
Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Osteo Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Muscle/Joint Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
LYMPHATIC/HEMATOLOGIC				
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Bleeding Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
ALLERGIC/IMMUNOLOGIC/INFECT.				
Multiple Sclerosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sarcoid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Sjogren's	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Cold Sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
PSYCHIATRIC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

Current Medications

Rx and over the counter: List names of medications including eye drops, vitamins and birth control pills.

Allergies to Medications? Yes No

Please list medication allergies:

Patient's Signature

Date