Welcome to Our Office!

Dr. Michael J. Haug, O.D.
Dr. Deborah S. Haug, O.D.
Dr. Jeanne W. Louie, O.D.
893 Santa Fe Dr.
Encinitas, CA 92024
ph: (760) 753-3500
www.visionsource-encinitas.com

HAUG OPTOMETRY

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: _____ Occupation: _____

E-Mail Address:_____ 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
- ❍ Burning
- ❍ Crossing eyes
- ❍ Double vision
- ❍ Dryness
- ❍ Flashes of Light
- ❍ Floaters/ Spots
- ❍ Eye discomfort
- ❍ Headaches
- ❍ Itchiness
- ❍ Sunlight sensitivity
- ❍ Excessive tearing
- ❍ Trouble seeing at night
- ❍ Uncomfortable glasses

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

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			
High Fever, Large Weight Loss/Gain	❍	❍	❍
DERMATOLOGIC (SKIN)	❍	❍	❍
NEUROLOGICAL			
Headaches	❍	❍	❍
Migranes	❍	❍	❍
Seizures	❍	❍	❍
ENDOCRINE			
Thyroid/Other Glands	❍	❍	❍
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever	❍	❍	❍
Sinus Congestion	❍	❍	❍
Runny Nose	❍	❍	❍
Post-Nasal Drip	❍	❍	❍
Chronic Cough	❍	❍	❍
Dry Throat/Mouth	❍	❍	❍
RESPIRATORY			
Asthma	❍	❍	❍
Chronic Bronchitis	❍	❍	❍
Emphysema	❍	❍	❍
VASCULAR/CARDIOVASCULAR			
Diabetes	❍	❍	❍
High Cholesterol	❍	❍	❍
Heart Pain	❍	❍	❍
High Blood Pressure	❍	❍	❍
Vascular Disease	❍	❍	❍
GASTROINTESTINAL			
Diarrhea	❍	❍	❍
Constipation	❍	❍	❍
Crohn's/Diverticulitis	❍	❍	❍
GENITOURINARY			
STD's/Kidney/Bladder	❍	❍	❍
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	❍	❍	❍
Osteo Arthritis	❍	❍	❍
Muscle/Joint Pain	❍	❍	❍
LYMPHATIC/HEMATOLOGIC			
Anemia	❍	❍	❍
Bleeding Problems	❍	❍	❍
ALLERGIC/IMMUNOLOGIC/INFECT.			
Multiple Sclerosis	❍	❍	❍
Lupus	❍	❍	❍
Sarcoid	❍	❍	❍
Sjogren's	❍	❍	❍
Cold Sores	❍	❍	❍
PSYCHIATRIC	❍	❍	❍

IF YOU ANSWER YES TO THE SYSTEM QUESTIONS, or have a condition not listed, please explain and list:

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