14 +

Welcome to

Today's Date ____/____/_____

Patient Information: (Please Print)

Name: Mr. Mrs. Ms. _____ Spouse's Name: _____

Address (1): _____ City: _____ State: ____ Zip: _____

Address (2): _____ Email Address: _____

Birthdate: _____/_____/_____ Age: _____ Social Security # _____

Home Ph: _____ Daytime Ph: _____ Cell Ph: _____

Children: _____ _____ _____ _____ _____

Emergency Contact: _____ Relation: _____ Phone #: _____

Marital Status (circle one): Single Married Divorced Widowed

Employment Status (circle one): Full Time Part Time Student Retired

Employer: _____ Occupation: _____

Sports/Hobbies: _____ Type of Insurance: _____

How did you hear about our clinic or whom may we thank? _____

Case History:

Date of Last Medical Exam: ____/____/_____ Primary Physician/Clinic: _____

Date of Last Eye Exam: ____/____/_____ Eye Doctor/Clinic: _____

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Reading only / Driving only

Do you wear contacts? Yes / No Type: _____ Solution used: _____

Wearing Schedule: **Daily** **Overnight** Replacement Schedule: **Daily** **2 Week** **Monthly** **Yearly**

Have you ever had an eye injury or surgery? Yes / No Please explain: _____

Have you used eye medication? Yes / No Please explain: _____

Have you ever been diagnosed with an eye disease? Yes / No Please explain: _____

Are you currently pregnant or nursing? Yes / No / N/A

What are your visual symptoms? (Please circle all that apply) (Please indicate Right, Left, or Both)

Blurred Vision/Distance	R L B	Burning Eyes	R L B	Floaters or Spots	R L B
Blurred Vision/Near	R L B	Mucus Discharge	R L B	Double Vision	R L B
Itchy Eyes	R L B	See Flashes	R L B	Tired Eyes	R L B
Eye Strain	R L B	Dry Eyes	R L B	See Halos	R L B
Loss of Vision	R L B	Wandering Eye	R L B	Eye Infections	R L B
Red Eyes	R L B	Poor Night Vision	R L B	Crossed Eyes	R L B
Droopy Lid	R L B	Eye Pain/Soreness	R L B	Watery Eyes	R L B
Poor Color Vision	R L B	Light Sensitivity	R L B	Sandy/Gritty Feeling	R L B
Lazy Eye	R L B	Migraines		Headaches	

PLEASE TURN OVER AND COMPLETE OTHER SIDE

Dr. _____
Date: _____

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** ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	**Endocrine:** ___**None** ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other	**Respiratory:** ___**None** ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional: ___**None** ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:	**Genitourinary:** ___**None** ___Kidney Disease ___Urinary Tract Infection ___STD - Herpetic/Chlamydia ___Other:	**Psychiatric:** ___**None** ___ADHD ___Depression ___Schizophrenia ___Other:
Neurological: ___**None** ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	**Musculoskeletal:** ___**None** ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	**Immunologic:** ___**None** ___AIDS or HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other:
Hematological: ___**None** ___Anemia ___Leukemia ___Other:	**Gastrointestinal:** ___**None** ___Crohn's ___Colitis ___Other:	**Ear/Nose/Throat:** ___**None** ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic: ___**None** ___Eczema ___Rosacea ___Psoriasis ___Other:	**Allergies:** (please list) ___**None** Drug: Reaction: Environmental: Reaction:	**Alcohol Use:** **Y** **N** Amount: **Tobacco Use:** **Y** **N** Amount:

Please list any medications and/or drugs that you are taking (including herbal):

1. _____For_____ 6. _____For_____
2. _____For_____ 7. _____For_____
3. _____For_____ 8. _____For_____
4. _____For_____ 9. _____For_____
5. _____For_____ 10._____For_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE/CONDITION		**FAMILY MEMBER**	**DISEASE/CONDITION**		**FAMILY MEMBER**
Lupus:	Yes/No	_____	Blindness:	Yes/No	_____
High Blood Pressure:	Yes/No	_____	Cataracts:	Yes/No	_____
Diabetes:	Yes/No	_____	Glaucoma:	Yes/No	_____
Cancer:	Yes/No	_____	Crossed Eyes/Lazy Eye:	Yes/No	_____
Heart Disease/Stroke:	Yes/No	_____	Macular Degeneration:	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Retinal Detachment:	Yes/No	_____