

Patient History:

| | | | |
|------------|--|---------------|----------|
| Name | <input type="checkbox"/> Male <input type="checkbox"/> Female | Date of Birth | Age |
| Address | City | State | Zip |
| Home Phone | Work Phone | Cell Phone | |
| Occupation | Employer or School | Insurance | Policy # |

Medical History:

Primary Care Physician: _____ Last Exam: ____/____/____

Please list any medications you are currently taking: _____

Do you have any allergies to medications? Yes No *If yes, please explain:* _____

Please list any major injuries, surgeries, or hospitalizations you have had: _____

Eye Health History:

1. Approximate date your last eye exam? _____ Dr.'s name: _____

2. Reason for today's exam: _____

3. Are you having any trouble with your vision? Yes No

If yes, please describe your problem(s): _____

4. Do you currently wear glasses? Yes No *If yes, please complete 4a and 4b below:*

| | |
|---|--|
| 4a. How long have you worn glasses? _____year(s) _____month(s) | 4b. Describe your current eye glasses: <input type="checkbox"/> Single <input type="checkbox"/> Bifocal <input type="checkbox"/> Trifocal <input type="checkbox"/> Progressive <input type="checkbox"/> Transition |
|---|--|

5. Do you wear contact lenses? Yes No

If no, do you have any interest in wearing contact lenses? Yes No

If yes, please complete 5a-c below:

| |
|--|
| 5a. Which brand of contact lenses do you use? _____ Are they comfortable? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, describe the problem:</i> _____ |
| 5b. Which brand of solution do you use: _____ |
| 5c. How often do you replace your contact lenses? <input type="checkbox"/> Daily <input type="checkbox"/> 2 weeks <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly |

*Contact Lens Policy: *If you are requesting a contact lens prescription, our office provides a full service program – evaluation, fitting, and follow-up. Our office does not release the contact lens prescription until you have been successfully evaluated and fitted.**

6. Please indicate whether you have had any of the following:

| | | |
|---|---|---|
| Eye injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No | Cataracts? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Glaucoma? <input type="checkbox"/> Yes <input type="checkbox"/> No | Burning in eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No | Itchy eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Excess tearing? <input type="checkbox"/> Yes <input type="checkbox"/> No | Floating spots? <input type="checkbox"/> Yes <input type="checkbox"/> No | Flashing lights? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Double vision? <input type="checkbox"/> Yes <input type="checkbox"/> No | Eye turn? <input type="checkbox"/> Yes <input type="checkbox"/> No | Dry eyes? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Light sensitivity? <input type="checkbox"/> Yes <input type="checkbox"/> No | Redness <input type="checkbox"/> Yes <input type="checkbox"/> No | Other: _____ |

7. Do you use eye drops regularly? Yes No *If yes, which brand?* _____

REVIEW OF SYSTEMS:

| | | |
|---|--|--|
| Cardiovascular High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve disease <input type="checkbox"/> Yes <input type="checkbox"/> No Previous heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No High cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No Hardening of the arteries <input type="checkbox"/> Yes <input type="checkbox"/> No | Social Smoke cigarettes <input type="checkbox"/> Yes <input type="checkbox"/> No History of smoking <input type="checkbox"/> Yes <input type="checkbox"/> No Drink alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No Use recreational drugs <input type="checkbox"/> Yes <input type="checkbox"/> No | Allergy/Immunologic Drug allergy <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No Environmental allergy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear/Nose/Throat Deafness <input type="checkbox"/> Yes <input type="checkbox"/> No Sinusitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Endocrine (Hormones) Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood/Lymphatic Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory Asthma/Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Depression <input type="checkbox"/> Yes <input type="checkbox"/> No Schizophrenia <input type="checkbox"/> Yes <input type="checkbox"/> No Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurological Previous stroke <input type="checkbox"/> Yes <input type="checkbox"/> No Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Musculoskeletal Osteoarthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Genitourinary Kidney stones <input type="checkbox"/> Yes <input type="checkbox"/> No Prostate cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Breast cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Gastrointestinal Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of Appetite <input type="checkbox"/> Yes <input type="checkbox"/> No |
| General Health Recent Fever <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No Unexpected weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Itching <input type="checkbox"/> Yes <input type="checkbox"/> No New moles/growths <input type="checkbox"/> Yes <input type="checkbox"/> No Rosacea <input type="checkbox"/> Yes <input type="checkbox"/> No Skin cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | |

FAMILY HISTORY: Please note any family member (parents, grandparents, siblings, children; living or deceased) who may have the following conditions:

| CONDITION | RELATION TO YOU |
|----------------------------|-----------------|
| Blindness | |
| Cataract | |
| Crossed eyes | |
| Glaucoma | |
| Macular degeneration | |
| Retinal detachment/disease | |
| Cancer | |

| CONDITION | RELATION TO YOU |
|---------------------|-----------------|
| Diabetes | |
| Heart disease | |
| High blood pressure | |
| Kidney disease | |
| Lupus | |
| Thyroid disease | |
| Other: | |

Reviewed by Dr.: _____ Date: _____