



General Information

Date: ___/___/___

Last Name _____ First Name _____ MI _____ DOB: ___/___/___

M or F SSN: ___/___/___ Spouse: _____ DOB: ___/___/___

Address: _____ City: _____ State: ___ Zip: _____

Home Ph:() _____ Work Ph:() _____ Cell Ph:() _____

Emergency Contact: _____ Relation: _____ Phone#:() _____

Employer/School: _____ Occupation/School Grade: _____

Email Address: _____ Sports/Hobbies: _____

CASE HISTORY / REASON FOR VISIT:

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

Date of Last Eye Exam: ___/___/___ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type: _____ Replace Schedule: _____

Have you ever had eye injuries? Yes No Which Eye? _____

Have you ever had eye surgeries? Yes No Why? _____

Have you taken eye medication? Yes No Why? _____

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed? _____

Glaucoma: Yes No When were you diagnosed? _____

Macular Degeneration: Yes No When were you diagnosed? _____

Please circle and explain any of the following past or present conditions that apply:

- Blurred Vision - Distance Burning Eyes Floaters or Spots Headaches
Blurred Vision - Near Itchy Eyes See Flashes Migraine Headaches
Double Vision Dry Eyes See Halos Loss of Vision
Eye Strain Red Eyes Poor Night Vision Crossed Eyes
Eye Infections Watery Eyes Poor Color Vision Light Sensitive

Are you currently pregnant or nursing? Yes No

Notes:

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 <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other: Medications:	Endocrine: __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other: Medications:	Respiratory: __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: Medications:
Constitutional: __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other: Medications:	Genitourinary: __ None <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> STD - Herpetic/Chlamydia <input type="checkbox"/> Other: Medications:	Psychiatric: __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: Medications:
Neurological: __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other: Medications:	Musculoskeletal: __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other: Medications:	Immunologic: __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other: Medications:
Hematological: __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: Medications:	Gastrointestinal: __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other: Medications:	Ear/Nose/Throat: __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other: Medications:
Dermatologic: __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: Medications:	Allergies (please list) __ None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

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

DISEASE / CONDITION

Blindness:	Yes	No	Who? _____
Cataracts:	Yes	No	Who? _____
Glaucoma:	Yes	No	Who? _____
Crossed Eyes:	Yes	No	Who? _____
Macular Degeneration:	Yes	No	Who? _____
Retinal Detachment:	Yes	No	Who? _____
High Blood Pressure:	Yes	No	Who? _____
Diabetes:	Yes	No	Who? _____
Cancer:	Yes	No	Who? _____
Heart Disease:	Yes	No	Who? _____
Thyroid Disease:	Yes	No	Who? _____

Who referred you to our clinic: Family Friend Yellow Pages Other (List) _____

Reviewed by:

Dr _____

Date _____