

Name (Print) \_\_\_\_\_ Age \_\_\_\_\_ M / F Date \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_ Any Special Eye or Vision Problems? \_\_\_\_\_

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

What problems are you having with your <b>EYES</b> ?	Yes (√)	No (√)	History of Present Symptoms (For Doctor/Staff)	Date of Last Eye Exam _____ Doctor _____
Blurred Vision– Far/ Near/ Middle				Date of Last Physical: _____ Doctor: _____ Phone Number: _____ Next Appt: _____
Sudden Vision Loss				
"Tired Eyes"				
Dryness of the Eye(s)				Pharmacy Name: _____ Phone Number: _____
Tearing / Redness / Discharge				
Itching / Burning / Gritty Feeling				Contact Lens Use for _____ years Soft _____ DW _____ Rigid _____ EW _____ Hard _____ Flex _____ Type _____ Age of CLs _____ Comfortable Yes No Solution(s) _____ Solution Allergies Yes No
Eyelid Swelling				
Eye Turn/Crossed Eye/Lazy Eye				
History of Eye Injury / Surgery				Single Vision – Distance or Near Vision / Bifocals / Trifocals / Progressives
History of Seeing Floaters				
Glaucoma				
Any Other Eye Diseases				
Computer Use			Hours/day: _____ Eye Strain Yes No	
Wear Glasses				

Wear Glasses \_\_\_\_\_ **Single Vision – Distance or Near Vision / Bifocals / Trifocals / Progressives**

Allergic to any Medications Please List: \_\_\_\_\_

Taking any Medications Please List: \_\_\_\_\_

Today I am Interested in:  Glasses  Sunglasses  Contact Lenses - Clear / Colored  LASIK

Females: Are you pregnant?  Yes  No  Not Sure Are you nursing?  Yes  No

<b>Personal Medical History</b>								
<u>Mental Status</u>	Yes	No	<u>Genitourinary</u>	Yes	No	<u>Pulmonary</u>	Yes	No
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____			Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurology</u>			<u>Cardiovascular</u>			<u>Allergies</u>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Heart	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Irregular Heart Beat	<input type="checkbox"/>	<input type="checkbox"/>	Sarcoidosis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrine</u>		
<u>Head</u>			<u>Hematology</u>			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	HIV +	<input type="checkbox"/>	<input type="checkbox"/>	<u>Gastrointestinal</u>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis _____	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Problems	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell / Trait	<input type="checkbox"/>	<input type="checkbox"/>	Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stress/Tension	<input type="checkbox"/>	<input type="checkbox"/>	<u>Muskuloskeletal</u>			Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
w/ Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Back Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pancreatic Disease	<input type="checkbox"/>	<input type="checkbox"/>
			Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>			

Do you use any tobacco products? \_\_\_\_\_ Do you consume any alcohol products? \_\_\_\_\_  
Describe any previous injuries or surgeries. \_\_\_\_\_

Has anyone in your FAMILY (blood relatives only) had any of the following medical problems?  
 Glaucoma Macular Degeneration Eye Disease Arthritis Lupus Diabetes Heart Disease High Blood Pressure  
 Thyroid Disease Asthma Tuberculosis Sjogren's Syndrome Lung Disease Stroke Cancer Other: \_\_\_\_\_

Patient / Parent Signature \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_