

# WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

*Please Print*

Patient's Full Legal Name _____	Date _____
Address _____	Phone _____
Zip Code _____	Work Phone _____
Birth Date ____/____/____ SS# ____/____/____	Last Eye Exam ____/____/____
Spouse _____	Prev. Eye Dr. _____
Birth Date ____/____/____ SS# ____/____/____	Last Medical Exam _____
If child, Parent or Guardian _____	Family Doctor _____
Student <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Grade _____	Occupation _____
Employer _____	Your Hobbies _____
List other family members who are our patients _____	_____
Who recommended us? _____	Email Address _____

## Eye Health History

Have YOU had any of the following?

- Cataracts
- Crossed Eye
- Droopy Eyelids
- Eye Injury
- Glaucoma
- Lazy Eye
- Macular Degeneration
- Protruding Eyes
- Refractive Surgery
- Retinal Disease

Are you using any prescription or non-prescription eye drops? No  Yes

List: \_\_\_\_\_  
 \_\_\_\_\_

Do you wear glasses? (If so, how old is your current pair? \_\_\_\_\_) No  Yes

Do you wear contact lenses? (If so, how old is your current pair? \_\_\_\_\_) No  Yes

Are they comfortable? No  Yes

Type  Rigid  Soft  Disposable  Non-Disposable  
 Sleep-In  Toric  Mono  Bifocal

Are you interested in contact lenses? No  Yes

Are you interested in refractive surgery? No  Yes

## Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Please Complete Both Sides of the Form**

**OVER**

## Social History

This information is strictly confidential, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History directly with the doctor.

Do you drive?  Yes  No If yes, do you have any vision difficulty when driving? Please describe:

Do you use tobacco?  Yes  No

Do you drink alcohol?  Yes  No

Do you use recreational drugs?  Yes  No

Have you ever been exposed to or infected with?  Gonorrhea  Hepatitis  HIV  Syphilis

Are you pregnant?  Yes  No Months: \_\_\_\_\_

Are you breastfeeding?  Yes  No

## Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	No	Yes		No	Yes
<b>Constitutional</b>			<b>Ears/Nose/Mouth/Throat</b>		
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary (skin)</b>			Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			Dry Mouth/Throat	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular / Cardiovascular</b>		
<b>Eyes</b>			Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>		
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sandy/Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Reflux	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genito-Urinary</b>		
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Bladder / Genital / Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones - Joints - Muscles</b>		
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Joint / Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	Osteo Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Sty/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic - Hematologic</b>		
Flashes/Floaters	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes/Eyestrain	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
<b>Endocrine</b>			<b>Psychiatric (Anxiety - Depression)</b>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>			
<b>Immunologic (Cancer)</b>	<input type="checkbox"/>	<input type="checkbox"/>			

## Medications

List all current prescription and over the counter medications

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Medical Allergies

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tech Initials \_\_\_\_\_ Date \_\_\_\_\_

Dr. Signature \_\_\_\_\_

Tech Initials \_\_\_\_\_ Review Date \_\_\_\_\_

Dr. Initial \_\_\_\_\_

Tech Initials \_\_\_\_\_ Review Date \_\_\_\_\_

Dr. Initial \_\_\_\_\_

Tech Initials \_\_\_\_\_ Review Date \_\_\_\_\_

Dr. Initial \_\_\_\_\_