

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENERAL INFORMATION**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □ Male □ Female

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If child, name of parents:

Note contact information you do NOT want to be used for appt. reminders/order availability: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer (or school): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation (or grade): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referral from doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Care: □ VSP □ EyeMed □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insured Social Security #

**What brings you to the office today?** □ Yearly eye exam □ School exam □ Glasses check □ Contact lens check

□ Emergency visit- Describe : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if you experience any of these symptoms on a regular basis:**

□ NO PROBLEMS

□ Distance vision blur

□ Near vision blur

□ Dry/burning eyes

□ Foreign body sensation

□ Excessive watering

□ Allergy/Itching

□ Flashes of light

□ Persistent redness

□ Floaters

□ Tired/Strained eyes

□ Discomfort with contacts

**Please check or been diagnosed/treated for:**

□ Glaucoma

□ Cataracts

□ Macular degeneration

□ Eye surgery/LASIK

□ Eye turn/Patching

□ Retinal tear/detachment

□ Macular degeneration

□ Eye injury

□ Dry eyes

Other:

**SOCIAL HISTORY:**

Routinely use/d tobacco products? □ No □ Yes: Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ /day Quit \_\_\_\_\_\_\_ years ago

Do you drink alcohol? □ No □ Yes: How often □ Occasionally □ 1/day □ > 1/day

Hobbies/Interests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY:**

Do you currently wear contact lenses? □ No □ Yes: What kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? □ No □ Yes: Age of current prescription : \_\_\_\_\_\_\_ year(s) Please continue on the next page

**Are you being treated or followed for any of the following?**

□ NO GENERAL HEALTH PROBLEMS

**CONSTITUTIONAL**

□ Developmental disability

□ Cancer

**EAR/NOSE/THROAT**

□ Hearing loss

□ Sinusitis

**NEUROLOGICAL**

□ Multiple sclerosis

□ Stroke

□ Migraines

□ Concussion

**PSYCHIATRIC**

□ Depression

□ Anxiety disorder

□ ADD/ADHD

**CARDIOVASCULAR**

□ High blood pressure

□ Heart disease

□ Vascular disease

**RESPIRATORY**

□ Asthma

□ COPD

□ Sleep apnea**GASTROINTESTINAL**

□ Crohn’s disease

□ Acid reflux

**GENITOURINARY**

□ Kidney disease

□ Pregnant/Nursing

**MUSCULOSKELETAL**

□ Arthritis

□ Fibromyalgia

□ Osteoporosis

**SKIN**

□ Rosacea

□ Eczema/Psoriasis

□ Herpes simplex/Cold sores

**ENDOCRINE**

□ Diabetes ✯SEE BELOW

□ Thyroid disease: Hypo / Hyper

**HEMOTOLOGIC/LYMPHATIC**

□ Anemia

□ High cholesterol

**ALLERGY/IMMUNOLOGIC**

□ Lupus

□ Rheumatoid arthritis

**OTHER**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Clinic/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Exam: \_\_\_\_\_\_\_\_\_\_\_\_

Height: Weight: ✯If diabetic, most recent A1C: Blood sugar:

**Allergies**

Are you allergic to any medications? □ No □ Yes - List meds: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any environmental allergies? □ No □ Yes- List: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there a family history of any of the following?**

**OCULAR HISTORY**

□ Cataracts □ Father □ Mother □ Brother □ Sister

□ Macular degen. □ Father □ Mother □ Brother □ Sister

□ Glaucoma □ Father □ Mother □ Brother □ Sister

□ Keratoconus □ Father □ Mother □ Brother □ Sister

□ Eye turn/Lazy eye □ Father □ Mother □ Brother □ Sister

**MEDICAL HISTORY**

□ Cancer □ Father □ Mother □ Brother □ Sister

□ Type I diabetes □ Father □ Mother □ Brother □ Sister

□ Type II diabetes □ Father □ Mother □ Brother □ Sister

□ Hypertension □ Father □ Mother □ Brother □ Sister

□ Thyroid disease □ Father □ Mother □ Brother □ Sister

There are two methods for viewing the back of the eye: taking a photograph or using drops to dilate the eye. Please choose one:

* Photos allow for detailed documentation that can be compared for slight changes year over year
	+ Unfortunately, eye insurance providers do not cover the $20/eye charge
* Dilation involves using drops to pharmacologically open the pupil. The disadvantage of using drops are:
	+ It takes 30 minutes for the drops to take effect (longer time in the office)
	+ Eyes are sensitive to light for at least 5 hours (we will provide disposable sun shields)
	+ Near vision is compromised for at least 5 hours