



Today's Date: \_\_\_\_\_

### PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M: \_\_\_ Male  Female  DOB: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_  
Email: \_\_\_\_\_ Referred by: \_\_\_\_\_  
SSN (used for ins. & person verification): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Primary Physician: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_ Vision Insurance: \_\_\_\_\_  
Primary Reason for Today's Visit: \_\_\_\_\_

### EYE HISTORY

Has anyone said that you have macular degeneration, cataracts, glaucoma, or any other eye problems?

Yes  No  Explain: \_\_\_\_\_

When was your last exam? \_\_\_\_\_ Previous Eye Doctor: \_\_\_\_\_ Town: \_\_\_\_\_

Do you wear glasses?  Yes  No What kind?  Reading  Progressive  Distance  Bifocal

Please check next to the following that you are experiencing (check all that apply):

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Flashes of Light | <input type="checkbox"/> Loss of Vision        | <input type="checkbox"/> Crossed/ Lazy Eye      | <input type="checkbox"/> Drooping Lids     |
| <input type="checkbox"/> Blurred Vision   | <input type="checkbox"/> Floaters              | <input type="checkbox"/> Double Vision          | <input type="checkbox"/> Headaches         |
| <input type="checkbox"/> Dryness          | <input type="checkbox"/> Sandy, gritty feeling | <input type="checkbox"/> Itching                | <input type="checkbox"/> Burning           |
| <input type="checkbox"/> Mucous           | <input type="checkbox"/> Redness               | <input type="checkbox"/> Foreign Body Sensation | <input type="checkbox"/> Excess Tearing    |
| <input type="checkbox"/> Glare            | <input type="checkbox"/> Light Sensitivity     | <input type="checkbox"/> Eye Pain               | <input type="checkbox"/> Infection of lids |
| <input type="checkbox"/> Tired Eyes       | <input type="checkbox"/> Other _____           |   |  |

Explain: \_\_\_\_\_

Have you ever had your pupils dilated? Yes  No  Complications? \_\_\_\_\_

Have you ever had any infections of the eye or lids? Yes  No  Explain: \_\_\_\_\_

Have you ever had any injury to your eye/s? Yes  No  Explain: \_\_\_\_\_

Have you ever had any ocular surgeries? Yes  No  Explain: \_\_\_\_\_

Is there anything else pertaining to your vision you'd like to share with us? Yes  No

Explain: \_\_\_\_\_

### CONTACT LENS

Do you currently wear contact lenses? Yes  No  Are you interested in contact lenses? Yes  No

What brand of lenses do you wear currently? \_\_\_\_\_

What kind of lenses are they? (Distance, astigmatism, bifocal etc) \_\_\_\_\_

How often do you dispose of your lenses? \_\_\_\_\_

What solution do you use to clean your lenses? \_\_\_\_\_

Any problems? \_\_\_\_\_

(TURN OVER)

**PATIENT MEDICAL HISTORY**

Are you currently experiencing any of the following? Please check all that apply:

- |  |  |                                     |   |                                       |                                    |
|--|--|-------------------------------------|---|---------------------------------------|------------------------------------|
| <input type="checkbox"/> Acid-Reflux     | <input type="checkbox"/> Acne                    | <input type="checkbox"/> AD/HD      | <input type="checkbox"/> AIDS           | <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Anemia          | <input type="checkbox"/> Angina                  | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Arrhythmia     | <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Asthma    |
| <input type="checkbox"/> Autism          | <input type="checkbox"/> Bi-polar                | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cholesterol  | <input type="checkbox"/> COPD      |
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Emphysema  | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Headache     | <input type="checkbox"/> Ulcer     |
| <input type="checkbox"/> Heart Murmur    | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Hernia     | <input type="checkbox"/> Herpes         | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Thyroid   |
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Hypoglycemia            | <input type="checkbox"/> IBS        | <input type="checkbox"/> Influenza      | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Kidney    |
| <input type="checkbox"/> Leukemia        | <input type="checkbox"/> Lung Disease            | <input type="checkbox"/> Lupus      | <input type="checkbox"/> Lyme disease   | <input type="checkbox"/> MS           | <input type="checkbox"/> MD        |
| <input type="checkbox"/> Parkinson's     | <input type="checkbox"/> Schizophrenia           | <input type="checkbox"/> Seizures   | <input type="checkbox"/> STD            | <input type="checkbox"/> Stroke       |                                    |
| <input type="checkbox"/> Cardiac Disease | <input type="checkbox"/> Cancer (specify: _____) |                                     | <input type="checkbox"/> Other _____    |                                       |                                    |

Explain: \_\_\_\_\_

Are you taking any medications? Yes  No  Please list \_\_\_\_\_

Are you allergic to any medications? Yes  No  Please list \_\_\_\_\_

**FAMILY HISTORY**

Does anyone in your family have any general health problems? \*Please follow the key when answering:

**M**-Mother **F**-Father **S**-Sister **B**-Brother **MGM**-Maternal Grandmother **MGF**-Maternal Grandfather  
**PGM**-Paternal Grandmother **PGF**-Paternal Grandfather **A**-Aunt **U**-Uncle **D**-Distant Relative

**OCULAR**

Blindness \_\_\_\_\_ Glaucoma \_\_\_\_\_ Macular Degeneration \_\_\_\_\_ Cataract \_\_\_\_\_ Retinal \_\_\_\_\_

**SYSTEMIC**

Arthritis \_\_\_\_\_ Cancer \_\_\_\_\_ (specify: \_\_\_\_\_) Diabetes \_\_\_\_\_ Hypertension \_\_\_\_\_  
Heart Disease \_\_\_\_\_ Kidney Disease \_\_\_\_\_ Lupus \_\_\_\_\_ Stroke \_\_\_\_\_ Thyroid Disease \_\_\_\_\_

**SOCIAL HISTORY**

Educational History: High School  Associates  Bachelors  Masters  Doctoral  Vocational   
Other: \_\_\_\_\_

Marital Status: Single  Married  Divorced  Widowed  Separated  Other: \_\_\_\_\_

Do you drive? Yes  No  \_\_\_\_\_

Do you drink alcohol? Yes  No  \_\_\_\_\_

Do you smoke tobacco? Yes  No  \_\_\_\_\_

Do you use recreational drugs? Yes  No  \_\_\_\_\_

**I agree that everything I have stated above pertaining to my health & personal history is accurate to the best of my knowledge**

Signature \_\_\_\_\_ Reviewed by \_\_\_\_\_