

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

Personal Medical History

<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>			Allergies	<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 _____