

Welcome to our office and thank you for allowing us to help you take care of your eyes and vision.

Please present all vision and medical information to the front desk staff. Please print.

**Patient Full Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Called name, if different\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If this is a new form what is TODAY’S DATE? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If NOT A NEW FORM do you have any changes to the following information? YES NO Today’s Date \_\_\_\_\_\_\_\_\_\_\_ IF yes, please write in changes.

If NOT A NEW FORM do you have any changes to the following information? YES NO Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_ IF yes, please write in changes.

**Eye and Vision Health History** Yes No Yes No

Do you currently wear glasses (If yes, how old is your current pair \_\_\_\_\_\_\_\_)? **** If no, have you ever worn glasses? ****

Would you like your glasses to have thinner and more lightweight lenses? **** Would you rather wear contact lenses? ****

Are you planning on purchasing a new pair of glasses today? **** Are you interested in Lasik Surgery? ****

Do you currently wear contact lenses (How old is your current pair \_\_\_\_\_\_\_\_)? **** Brand of Contacts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cleaning solution \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you comfortable with your lenses? **** If no, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of CLs (check all that apply): Sphere Toric Bifocal Monovision Soft Rigid Daily 2 week Monthly Yearly

About how long do you wear your contacts in a normal day? 8 hrs. 15 hrs. continuously Do you wear UV protection for your eyes? Y N

Are you using any prescription or non-prescription eye drops? Y N List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do **you currently** have any of the following? Have **you ever** had any of the following?

 Yes No Yes No Yes No Yes No

Cataracts Dry/Gritty Eyes  ****Itchy Eyes****Droopy Eyelids 

Macular Degeneration Mucous in eyes  ****Watery Eyes ****Crossed/Lazy Eye 

Protruding/Recessed Eye Blurry Vision  **** Eye Surgery (Type?) 

Glaucoma Burning Eyes  **** Foreign Object in Eye 

Retinal Disease Light Sensitivity  **** Floaters 

**Social History**

This information is held in the utmost confidence. If you would prefer to speak directly with the doctor about this information, please check here: 

Do you smoke? ****yes  no If yes, packs/day \_\_\_\_\_\_ approx. how many years? \_\_\_\_\_\_\_\_ Do you use smokeless tobacco?  yes  no

If former smoker, quit for how long? Within last year 1-2 years 3-4 years 5-10 years 10+ years

Do you drink?  yes  no If yes, please circle one: socially 1-2 drinks daily 3+ drinks daily dependency

Do you currently or have you ever used narcotics recreationally or been unintentionally dependent on them?  yes  no

Have you ever been infected with or exposed to… Herpes  HIV  Gonorrhea  Hepatitis  Syphilis  Tuberculosis

Have you ever had a blood transfusion?  yes  no

Do you have siblings Y / N, if Yes where are you in the birth order? 1 2 3 4 5 6+

Do you use or have you ever used recreational drugs, including IV drugs?  yes  no

Do you drive?  yes  no Do you currently have any problems with glare, halos, or low light driving? yes no Is it progressive?  yes  no

How many total hours per day are you on a computer and/or a handheld digital device? \_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant?  yes  no Are you breastfeeding?  yes  no

**Please complete the back side of this form as well. Thank you.**

 **PATIENT’S NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you currently have any of the following problems? Yes No If YES, please explain:**

Cardio/Circulatory (pain, irregular heartbeat, blood pressure) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chronic fever, unexpected weight loss/gain, fatigue **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ear/nose/throat/mouth (hearing loss, sinus, sore throat) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Endocrine System (diabetes, thyroid problems) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gastrointestinal (heartburn, abdominal pain, diarrhea) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Genitourinary System (discomfort, blood in urine, reproductive) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hemato/Lymphatic (lymphoma, swollen legs/feet, clotting) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunologic (Lupus, HIV/AIDS, allergic reactions) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Problems (rashes, excessive dryness, rosacea) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Musculoskeletal (muscle aches, joint pain, swollen joints) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Neurologic (numbness, weakness, headaches, paralysis) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatric System (depression, anxiety, mood affect) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Respiratory System (shortness of breath, wheezing, cough) **􀀁 􀀁** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eye injury: previously **** currently? **** explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family and Personal Medical History**

**Have you or immediate family member (parent, child, grandparent, sibling) ever had any of the following conditions?**

 **Self Family Self Family Self Family Self Family**

Cataract **􀀁 􀀁** High Blood Pressure **􀀁 􀀁** Diabetes **􀀁 􀀁**  Migraines **􀀁 􀀁**

Glaucoma **􀀁 􀀁** Heart Disease **􀀁 􀀁** Asthma **􀀁 􀀁** Seizures/Epilepsy **􀀁 􀀁**

Crossed/Lazy Eye **􀀁 􀀁** Stroke **􀀁 􀀁** Arthritis **􀀁 􀀁** Anemia **􀀁 􀀁**

Retinal Detachment **􀀁 􀀁** Heart arrhythmia **􀀁 􀀁** Sinus Problems **􀀁 􀀁** Thyroid Disease **􀀁 􀀁**

Retinal Degeneration **􀀁 􀀁** Chronic Bronchitis **􀀁 􀀁** Tuberculosis **􀀁 􀀁** Cancer **􀀁 􀀁**

Macular Degeneration **􀀁 􀀁** Bleeding Problems **􀀁 􀀁** HIV/AIDS **􀀁 􀀁** Liver disease **􀀁** **􀀁**

Blindness **􀀁 􀀁** Inflammatory Bowel Dz **􀀁 􀀁** Lupus **􀀁 􀀁**

When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Surgeries:** List any previous surgeries, including eye surgeries and laser procedures:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: Please list all of your medications, including dosage. We will gladly copy or input it directly in our system.

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**Allergies:** Please list any **medical** or **environment** allergies you have.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any persons which you give permission to obtain your health information.** You may notify us to change this information at any time.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to you \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tech/Dr.’s Init’s Today’s Date

**\*Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_