

## **Patient Information**

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

Name: (last) \_\_\_\_\_, (first) \_\_\_\_\_ (initial) \_\_\_\_\_

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

Phone: (home) \_\_\_\_\_ (work/cell) \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_  
Please circle the best number to reach you

Social Security # \_\_\_\_\_ Status: Mr. Ms. Miss. Mrs. Dr. Sex: M F

Email Address (responsible party) \_\_\_\_\_@\_\_\_\_\_

Birth State \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Medical Doctor \_\_\_\_\_ City: \_\_\_\_\_ Last Exam Date: \_\_\_\_\_

Previous Eye Doctor \_\_\_\_\_ City: \_\_\_\_\_ Last Exam Date: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

### **Medical History:**

Allergies to medications or latex? Y N If yes, please list \_\_\_\_\_

List all medications/ Ocular medications you are currently taking \_\_\_\_\_

List all major injuries, surgeries, illnesses, and hospitalizations you've had \_\_\_\_\_

Are you currently pregnant or nursing? Y N Due Date \_\_\_\_\_

Do you currently wear glasses? Y N Age of lenses \_\_\_\_\_ Are you interested in new glasses today? Y N

Do you use a computer? Y N How many hours a day? \_\_\_\_\_

Do you currently wear contacts? Y N If yes, type of contact lenses: \_\_\_\_\_

When did you start wearing contact lenses? \_\_\_\_\_ Contacts last date worn \_\_\_\_\_

If no, are you now interested in trying contact lenses? Y N

### ***Contact Lens design requires addition testing & an additional fee, which may not be covered by insurance***

Are you interested in Refractive surgery? Y N (LASIK, PRK, CK, Lensectomy)? Y N

Profession: \_\_\_\_\_ Do you require special vision needs in your line of work? Y N

If yes, specify: \_\_\_\_\_

### **Self/Family History:** Please note any family/self (blood related, living or deceased) history for the following conditions.

DISEASE/CONDITION	Self:	Yes	No	?	Family:	Yes	No	?	RELATIONSHIP TO YOU
Arthritis		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amblyopia/ Lazy Eye		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blindness		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Corneal Abrasion		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes/ Strabismus		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Eyes		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

**OVER**

	Self: Yes	No	?	Family: Yes	No	?	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Herpes Simplex/Zoster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Keratoconus/ Corneal Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Recurrent Corneal Abrasion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sjrogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ocular Trauma/ Foreign Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, explain:			_____
Refractive Surgery (Lasik, PRK, RK)	Date/Type		_____				

**Social History:** This information is kept *strictly* confidential. However, you may discuss this portion with the doctor directly if you prefer.  Yes, I would prefer to discuss my social history directly with my doctor.

Do you drive? Y N Do you have any problems when driving? \_\_\_\_\_

Do you currently OR have you ever used tobacco? Y N How Often? \_\_\_\_\_

Do you drink alcohol? Y N How often? \_\_\_\_\_

Do you use illegal drugs? Y N type/amount/how long \_\_\_\_\_

Have you been exposed to/infected with: Gonorrhea Hepatitis HIV Syphilis

**Review of Self Systems:** Do *you* currently, or have you ever, had any problems in the following areas?

SYSTEM	YES	NO	?	SYSTEM	YES	NO	?
<b>Constitutional</b>				<b>Gastrointestinal</b>			
-fever, weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Integumentary (skin)</b>				-Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Healing Problems/Keloid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Genitourinary</b>			
-Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-Rosacae	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones/Joints/Muscles</b>			
-Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>				-muscle pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Lymphatic/Hematologic</b>			
<b>Eyes</b>				-anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-bleeding problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Allergic/Immunologic</b>			
-distorted vision/halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-double vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric</b>			
-dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-Claustrophobic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Vascular/Cardiovascular</b>			
-sandy/gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-heart pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-high blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-foreign body sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-excess tearing/watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	- Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Respiratory</b>			
-eye pain or soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-chronic infection (eye or lid)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-sties or chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	-emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-flashes/floaters in vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Endocrine</b>			
<b>Ears, Nose Mouth or Throat</b>				-thyroid/glandular problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
-allergies/hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If you checked yes to <i>any</i> of the above or have a condition not listed, please explain: _____			
-sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
-runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
-post-nasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
-chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
-dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
-Sjrogrens Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Patient Signature (Or parent if a minor) \_\_\_\_\_ Date \_\_\_\_\_