I Care • Eye Care

Martin Optical Phone: 847-290-1131

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____MI _____DOB: ____/____/____

☐M or ☐F SSN: _____ / _____ / _____ Marital Status: ☐Married ☐Single ☐Divorced

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____-_____-_____ Work Ph: _____-_____-_____ Cell Ph: _____-_____-_____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: _____-_____-_____

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses?

☐Yes ☐No ☐All the time ☐Sometimes ☐Work Only ☐Reading only ☐Driving only

How old are your present glasses: _____Do you wear prescription Sun Wear:☐Yes ☐No

Do you wear contacts? ☐Yes ☐No Type:_____

Solution Used: _____

Wearing schedule: ☐Daily ☐Overnight Replacement schedule: ☐Daily ☐2 week ☐Monthly ☐Yearly

If you do not wear contacts, are you interested in getting them? ☐Yes ☐No

Have you ever had eye injuries? ☐Yes ☐No Which Eye?_____

Have you ever had eye surgeries? ☐Yes ☐No Why?_____

Have you used eye medication? ☐Yes ☐No Why?_____

Are you currently pregnant or nursing? ☐Yes ☐No ☐N/A

Have you ever been diagnosed with?

Cataracts: ☐Yes ☐No When were you diagnosed?_____

Glaucoma: ☐Yes ☐No When were you diagnosed?_____

Macular Degeneration:☐Yes ☐No When were you diagnosed?_____

What are your visual symptoms: Please check any that apply:

- ☐Blurred Vision/Distance
- ☐Blurred Vision/Near
- ☐Double Vision
- ☐Eye Strain
- ☐Eye Infections
- ☐Eye Pain/Soreness
- ☐Tired eyes
- ☐Burning Eyes
- ☐Itchy Eyes
- ☐Dry Eyes
- ☐Red Eyes
- ☐Watery Eyes
- ☐Wandering eye
- ☐Mucus Discharge
- ☐Floaters or Spots
- ☐See Flashes
- ☐See Halos
- ☐Poor Night Vision
- ☐Headaches
- ☐Migraine Headaches
- ☐Loss of Vision
- ☐Crossed Eyes
- ☐Light Sensitive
- ☐Sandy/Gritty Feeling
- ☐Poor Color Vision
- ☐Droopy Lid

How did you hear about our office? _____

Are you interested in LASIK? ☐Yes ☐No

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS)

Please check if any of the following applies to you, and list any medications for each condition that you check. If you have none of these conditions, **please check none.**

Cardiovascular: ☐ None ☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ Other: _____	**Endocrine:** ☐ None ☐ Non-Insulin Dependent Diabetes ☐ Insulin Dependent Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other: _____	**Respiratory:** ☐ None ☐ Ashma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other: _____
Constitutional: ☐ None ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other: _____	**Ocular:** ☐ None ☐ Glaucoma ☐ Macular Degeneration ☐ Detached Retina ☐ Other: _____	**Psychiatric:** ☐ None ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other: _____
Neurological: ☐ None ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other: _____	**Musculoskeletal:** ☐ None ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other: _____	**Immunologic:** ☐ None ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other: _____
Hematological: ☐ None ☐ Anemia ☐ Leukemia ☐ Other: _____	**Gastrointestinal:** ☐ None ☐ Crohn's ☐ Colitis ☐ Other: _____	**Ear/Nose/Throat:** ☐ None ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other: _____
Dermatologic: ☐ None ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other: _____	**Allergies:** ☐ None Drug: _____ _____ Environmental:_____ _____	**Alcohol Use:** ☐ Yes ☐ No Amount: _____ Tobacco Use: ☐ Yes ☐ No Amount: _____

Please list physical reaction's to above allergies: _____

Please list any medications and/or drugs that you are taking (including herbal):

1. _____ For: _____ 2. _____ For: _____
3. _____ For: _____ 4. _____ For: _____
5. _____ For: _____ 6. _____ For: _____
7. _____ For: _____ 8. _____ For: _____
9. _____ For: _____ 10. _____ For: _____

FAMILY HISTORY:

Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

Retinal Detachment:	☐ Y	☐ N	Blindness:	☐ Y	☐ N	Cancer	☐ Y	☐ N
High Blood Pressure:	☐ Y	☐ N	Cataracts:	☐ Y	☐ N	Crossed Eyes	☐ Y	☐ N
Diabetes:	☐ Y	☐ N	Glaucoma:	☐ Y	☐ N	Macular Degeneration	☐ Y	☐ N
Thyroid Disease:	☐ Y	☐ N	Lupus:	☐ Y	☐ N			

Reviewed by:_____ **Date:** _____