DATE: _____

PATIENT NAME: _____ **DOB:** _____

PERSONAL EYE INFORMATION

Date of Last Eye Examination: _____ Doctor's Name: _____

Your reason(s) for visiting our office today: (please check all applicable items)

___ General check-up	___ Headaches	___ Want contact lenses
___ Laser vision consultation	___ Light sensitivity	___ Lost or broken glasses
___ Want new eyeglasses	___ Eyes water	___ Eyes itch
___ Blurred distance vision	___ Eyes feel dry	___ Pain in eyes
___ Blurred intermediate vision	___ Flashes of lights	___ Floating spots in vision
___ Blurred near vision	___ Eyes feel tired	___ Red Eye
___ Night vision problems	___ Double vision	___ Other (Explain)_____

Contact Lens Questionnaire:

- Are you wearing contact lenses today? ___ No ___ Yes
- If yes, what type? ___ Soft ___ Rigid/ Gas Permeable, What Brand? _____
- What type of solution do you use to clean and disinfect? _____
- Have your worn contact lenses in the past? If so, please tell us why you quit. _____

SOCIAL HISTORY:

- Do you any visual problems while driving? ___ No ____ Yes (describe) _____
- Do you use tobacco products? _____ No ____Yes (Type)_____ How long: _____
- Do you drink alcohol? _____ No ____Yes (Type) _____ How often: _____
- Do you use illegal drugs? _____ No ____Yes (Type) _____ How long: _____

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

MEDICAL HISTORY

Date of Last Medical Exam: _____ Name of Medical Doctor: _____ Phone #: _____

List your **MEDICATIONS** (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

_____

Are you allergic to any medications? ___ NO ___YES (please list) _____

List all major surgeries, injuries and/ or hospitalizations: _____

GENERAL HEALTH	**ENDROCRINE**	**SKIN**
___ None	___None	___None
___Weight loss/gain	___Diabetes ___Type I ___Type II	___Eczema
___Fever	When diagnosed:	___Rosacea
___Fatigue	Last HbA1c	___Other (list):
___Pregnant	___Thyroid (specify)	**MUSCLE/SKELETAL**
___Breast Feeding	___Other (list):	___None
___Trauma	**GASTROINTESTINAL**	___Arthritis
___Other (list):	___None	___Fibromyalgia
OCULAR	___Crohn's Disease	___Ankylosing Spondylitis
___None	___Colitis	___Other (list):
___Blindness	___Acid reflux/ulcer	**NEUROLOGICAL**
___Cataracts	___Hepatitis	___None
___Glaucoma	___Other (list):	___Multiple Sclerosis
___Macular Degeneration	**GENITAL/URINARY**	___Epilepsy
___Retinal Condition	___None	___Tremors
___Other (list):	___Urinary Tract Infection	___Other (list):
IMMUNOLOGIC	___Herpes	**PSYCHIATRIC**
___None	___Chlamydia	___None
___Lupus (SLE)	___Syphilis	___Anxiety
___Rheumatoid Arthritis	___Other (list):	___Depression
___Environmental Allergies	**EARS, NOSE, THROAT**	___Bipolar
___HIV Positive	___None	___Schizophrenia
___Other (list):	___Runny Nose, Post Nasal Drip	___Other (list):
CARDIOVASCULAR	___Sinusitis	**RESPIRATORY**
___None	___Upper Respiratory Infection	___None
___High Blood Pressure	___Other (list):	___Asthma
___Heart Disease	**HEMATOLOGIC LYMPHATIC**	___Bronchitis
___Cholesterol	___None	___Emphysema
___Vascular disease	___Anemia	___Other (list):
___Stroke	___Leukemia	
___Heart Attack	___Bleeding Disorder	
___Other (list):	___Other (list):	

Family History

FAMILY HISTORY	**YES**	WHO? (BLOOD RELATIVES ONLY)	**FAMILY HISTORY**	**YES**	WHO? (BLOOD RELATIVES ONLY)
ARTHRITIS			BLINDNESS		
CANCER			CATARACTS		
DIABETES			CROSSED EYES		
HEART DISEASE			GLAUCOMA		
HIGH BLOOD PRESSURE			MACULAR DEGENERATION		
HIGH CHOLESTEROL			RETINAL DETACHMENT		
KIDNEY DISEASE			LAZY EYE		
LUPUS			RETINAL DISEASE		
THYROID DISEASE					
LUNG DISEASE					