WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Date _____

Patient's Full Legal Name _____

DOB _____/_____/_____ SSN# _____/_____/_____

Address _____

City/St _____ Zip _____ Country _____

Type of Address ❑ Home ❑ Office

Home Phone_____

Cell Phone _____

Work Phone _____

Email _____

Note: It is now required we obtain an email address so we can upload your visit to the patient portal

Marital Status ❑ M ❑ S ❑ D ❑ W

Spouses Name_____

DOB _____/_____/_____ SSN# _____/_____/_____

Primary Language ❑ English ❑ Spanish ❑ Other

Special Needs: ❑ Hearing Impaired ❑ Translator ❑ Wheelchair

Race ❑ White ❑ African American ❑ Asian

❑ Other _____ ❑ Decline to Answer

Ethnicity ❑ Hispanic or Latino ❑ Non-Hispanic or Latino

❑ Unknown ❑ Decline to Answer

Employer _____ Occupation _____

Last PCP Visit _____/_____/_____ PCP Doctor_____

Last Eye Exam _____/_____/_____

Prev. Eye Dr. _____

Miscellaneous

List any previous surgeries with dates

_____

_____

_____

Are You Pregnant? ❑ Yes ❑ No

Are You Breastfeeding? ❑ Yes ❑ No

Hobbies/Recreational Sports you enjoy _____

_____

_____

How many hours per day do you use a computer? _____

Do you wear glasses? ❑ Yes ❑ No

Do you wear contact lenses? ❑ Yes ❑ No

Are you interested in contact lenses? ❑ Yes ❑ No

Are you interested in refractive surgery? ❑ Yes ❑ No

Do you perform fine or close-up work? ❑ Yes ❑ No

Are you outdoors all or part of the time? ❑ Yes ❑ No

Do you have trouble reading signs when driving at night? ❑ Yes ❑ No

Are you bothered by glare from: Overhead lighting? ❑ Yes ❑ No

A computer screen? ❑ Yes ❑ No

Oncoming headlights at night? ❑ Yes ❑ No

Are you sensitive in bright sunlight? ❑ Yes ❑ No

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No
Constitutional		
Fever, Weight Loss/Gain	❑	❑
Cardiovascular		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
High Cholesterol	❑	❑
Stroke	❑	❑
Vascular Disease	❑	❑
Ears/Nose/Mouth/Throat		
Allergies	❑	❑
Sinus Congestion	❑	❑
Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Mouth/Throat	❑	❑
Respiratory		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
Sleep Apnea	❑	❑

	Yes	No
Gastrointestinal		
Constipation	❑	❑
Crohn's Disease	❑	❑
Hepatitis A	❑	❑
Hepatitis B	❑	❑
Hepatitis C	❑	❑
Ulcer / Reflux	❑	❑
Genito-Urinary		
Bladder / Genital / Kidney	❑	❑
Herpes Simplex	❑	❑
Prostate	❑	❑
Musculoskeletal		
Joint / Muscle Pain	❑	❑
Osteo Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Integumentary (skin)		
Skin Cancer	❑	❑
Skin Disease	❑	❑
Herpes Zoster/Shingles	❑	❑

	Yes	No
Neurological		
Headaches	❑	❑
Migraines	❑	❑
Multiple Sclerosis	❑	❑
Gout	❑	❑
Seizures	❑	❑
Psychiatric		
Anxiety / Depression	❑	❑
Endocrine		
Diabetes Type I	❑	❑
Diabetes Type II	❑	❑
Thyroid/Other Glands	❑	❑
Lymphatic – Hematologic		
Anemia	❑	❑
Bleeding Problems	❑	❑
Allergic / Immunologic		
Eczema	❑	❑
Hives	❑	❑
Lupus	❑	❑
Organ transplant	❑	❑

Please Complete Both Sides of the Form OVER →

Ocular History

(mark yes or no to each question)

Age-related macular degeneration	❑ Yes	❑ No	Injury to the eye region	❑ Yes	❑ No
Amblyopia (Lazy eye)	❑ Yes	❑ No	Keratoconus	❑ Yes	❑ No
Blindness-one eye	❑ Yes	❑ No	Retinopathy	❑ Yes	❑ No
Bindness-both eyes	❑ Yes	❑ No	Strabismus (Crossed eyes)	❑ Yes	❑ No
Cataracts	❑ Yes	❑ No	Tear film insufficiency (dry eyes)	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Other _____		
History of refractive surgery	❑ Yes	❑ No	_____		

Patient's Past Medical History

(mark yes or no to each question)

Acquired Immune Deficiency Syndrome (AIDS)	❑ Yes	❑ No	Human immunodeficiency virus infection (HIV)	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No	Hypercholesterolemia (high cholesterol)	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Hypertensive disorder (Hypertension)	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Seasonal allergy	❑ Yes	❑ No
Chronic obstructive lung disease (COPD)	❑ Yes	❑ No	Thyroid dysfunction	❑ Yes	❑ No
Diabetes mellitus	❑ Yes	❑ No	Mental disorder	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Rheumatoid arthritis	❑ Yes	❑ No
Heart disease	❑ Yes	❑ No			

Family Health History

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	❑ Yes	❑ No _____	Strabismus (cross eyes)	❑ Yes	❑ No _____
Blindness and/or vision impairment	❑ Yes	❑ No _____	Arthritis	❑ Yes	❑ No _____
Cataract	❑ Yes	❑ No _____	Cancer	❑ Yes	❑ No _____
Macular Degeneration	❑ Yes	❑ No _____	Diabetes mellitus	❑ Yes	❑ No _____
Glaucoma	❑ Yes	❑ No _____	Hypertension (high blood pressure)	❑ Yes	❑ No _____
Retinal disorder	❑ Yes	❑ No _____	Cardiovascular disease	❑ Yes	❑ No _____
			Stroke	❑ Yes	❑ No _____

Social History (check one for each question)

Are you a drug user? ❑ Yes ❑ No

Are you a: ❑ Non-drinker ❑ Social drinker

Tobacco Use (mark which one applies)

❑ Heavy tobacco smoker ❑ Light tobacco smoker

❑ Never a smoker ❑ Former smoker

Medications

List all CURRENT prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

_____

_____

_____

_____

❑ No Medications

Medication Allergies

List any allergies you may have and reaction.

_____

_____

_____

_____

❑ No Medication Allergies

Tech Initials _____ Date _____ Dr. Signature _____

Tech Initials _____ Review Date _____ Dr. Initial _____

Tech Initials _____ Review Date _____ Dr. Initial _____

Tech Initials _____ Review Date _____ Dr. Initial _____