

**General Information:**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Gender M F SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Occupation/Grade: \_\_\_\_\_ Employer/School: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_  
E-mail: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_  
Emergency Contact Phone: ( ) \_\_\_\_\_ Marital Status: Single / Married / Divorced / Widowed  
How did you find out about our office, or who referred you to our office? \_\_\_\_\_

**Case History / Reason for Visit:**

Date of Last Medical Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Primary Care Physician: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Date of Last Eye Exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Eye Doctor's Name: \_\_\_\_\_ Clinic: \_\_\_\_\_  
Do you wear: Glasses / Contact Lenses / Both Used for what: Distance / Reading / Full-time / Occasionally / Driving only  
How old are your current Glasses? \_\_\_\_\_ How old are your current Contact Lenses? \_\_\_\_\_  
How many hours per day do you wear your Contact Lenses? \_\_\_\_\_ Do you sleep in your Contact Lenses? Yes / No  
Contact Lens solution used: \_\_\_\_\_ How often do you replace your Contact Lenses? Daily 2 wk Monthly Yearly

**Vision Complaints & Ocular History (circle any that apply):**

Are you having problems seeing with your glasses/contacts? Yes / No Where are the problems? Distance / Near / Computer  
Which Eye? Right / Left / Both How long have you noticed this problem? \_\_\_\_\_ Severity: Mild / Mod. / Severe  
How often does this problem occur? Constantly / Occasionally / Rarely How did it begin: Gradually / Suddenly

**Patient Medical History Information: (please indicate if you have or have ever had any of the following conditions)**

- |                                                 |                                                   |                                              |                                                 |                                             |
|-------------------------------------------------|---------------------------------------------------|----------------------------------------------|-------------------------------------------------|---------------------------------------------|
| <b>Allergic/Immunologic</b> Neg.____            | <b>Endocrine</b> Neg.____                         | <b>Gastrointestinal</b> Neg.____             | <b>Musculoskeletal</b> Neg.____                 | <b>Respiratory</b> Neg.____                 |
| <input type="checkbox"/> Drug allergy           | <input type="checkbox"/> Diabetes, Type 1         | <input type="checkbox"/> Crohn's             | <input type="checkbox"/> Fibromyalgia           | <input type="checkbox"/> Asthma             |
| <input type="checkbox"/> Environmental allergy  | <input type="checkbox"/> Diabetes, Type 2         | <input type="checkbox"/> Colitis             | <input type="checkbox"/> Muscular dystrophy     | <input type="checkbox"/> Bronchitis         |
| <input type="checkbox"/> Seasonal allergies     | <input type="checkbox"/> Thyroid dysfunction      | <input type="checkbox"/> Ulcer               | <input type="checkbox"/> Osteoarthritis         | <input type="checkbox"/> Emphysema          |
| <input type="checkbox"/> Rheumatoid arthritis   | <input type="checkbox"/> Hormonal dysfunction     | <input type="checkbox"/> Acid Reflux         | <input type="checkbox"/> Ankylosing spondylitis | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Other:                 | <input type="checkbox"/> Other:                   | <input type="checkbox"/> Other:              | <input type="checkbox"/> Other:                 | <input type="checkbox"/> Other:             |
| <b>Cardiovascular</b> Neg.____                  | <b>Constitutional</b> Neg.____                    | <b>Psychiatric</b> Neg.____                  | <b>Integumentary</b> Neg.____                   | <b>Neurological</b> Neg.____                |
| <input type="checkbox"/> Heart disease          | <input type="checkbox"/> Weight loss              | <input type="checkbox"/> Depression          | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Epilepsy           |
| <input type="checkbox"/> Hypertension           | <input type="checkbox"/> Developmental disability | <input type="checkbox"/> Panic disorder      | <input type="checkbox"/> Rosacea                | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Stroke                 | <input type="checkbox"/> Fever                    | <input type="checkbox"/> Schizophrenia       | <input type="checkbox"/> Psoriasis              | <input type="checkbox"/> Other:             |
| <input type="checkbox"/> Vascular disease       | <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Bipolar Disorder    | <input type="checkbox"/> Other:                 |                                             |
| <input type="checkbox"/> Elevated Cholesterol   | <input type="checkbox"/> Trauma                   | <input type="checkbox"/> Other:              |                                                 |                                             |
| <input type="checkbox"/> Other:                 | <input type="checkbox"/> Other:                   |                                              |                                                 |                                             |
| <b>Genitourinary</b> Neg.____                   | <b>Blood/Lymph</b> Neg.____                       | <b>Head / ENT</b> Neg.____                   | <b>Eyes</b> Neg.____                            |                                             |
| <input type="checkbox"/> Urinary Tract Infect.  | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Dry Mouth           | <input type="checkbox"/> Glaucoma               |                                             |
| <input type="checkbox"/> Uncontrollable bladder | <input type="checkbox"/> Large volume blood loss  | <input type="checkbox"/> Headache            | <input type="checkbox"/> Macular Degeneration   |                                             |
| <input type="checkbox"/> Bladder dysfunction    | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Resp. Tract Infect. | <input type="checkbox"/> Cataracts              |                                             |
| <input type="checkbox"/> Other:                 | <input type="checkbox"/> Other:                   | <input type="checkbox"/> Other               | <input type="checkbox"/> Eye Surgery            |                                             |
|                                                 |                                                   |                                              | <input type="checkbox"/> Flashes/Floaters       |                                             |
|                                                 |                                                   |                                              | <input type="checkbox"/> Strabismus / Amblyopia |                                             |
|                                                 |                                                   |                                              | <input type="checkbox"/> Dry Eye                |                                             |
|                                                 |                                                   |                                              | <input type="checkbox"/> Other                  |                                             |

**Please list all systemic & ocular medications you are taking:**

\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_  
\_\_\_\_\_ For what? \_\_\_\_\_

**Please list any drug/medication allergies you know of:**

\_\_\_\_\_ What happens? \_\_\_\_\_  
\_\_\_\_\_ What happens? \_\_\_\_\_

**Family Health History: (circle all that apply)**

**Ocular:** Glaucoma Cataracts Macular Degen. Blindness Surgery  
Retinal Detachment Other: \_\_\_\_\_  
**Medical:** Hypertension Heart Disease Cholesterol Diabetes Cancer  
Stroke Lupus Other: \_\_\_\_\_

**Social History:**

Are you a smoker? Y / N If so, how much? \_\_\_\_\_  
Do you drink alcohol? Y / N If so, how much? \_\_\_\_\_  
Recreational drug use? Y / N If so, how much? \_\_\_\_\_  
Are you sexually active? Y / N STD?: Y / N