Name: _____ Date of Birth:_____ SS#: _____

Emergency Contact: _____ Emergency Phone: _____

Family Dr. _____ Normal Pharmacy _____

CHILDREN or IF INSURANCE IS UNDER ANOTHER PERSONS NAME

Parent or Insured's Name:_____ Employer: _____

Address: _____ Social Security #: _____

_____ Date of Birth:_____

Have you or a family member ever been treated for any of the following conditions?

Circle Yes for all that apply to **YOU**. If a family member has had the condition please list their relationship to you, such as **father, mother, brother, sister** etc.

Condition	Myself	Family Member/who?	Condition	Myself	Family Member/who?
Glaucoma	Yes	Yes_____	Cancer	Yes	Yes_____
Cataracts	Yes	Yes_____	Stroke	Yes	Yes_____
Macular Degeneration	Yes	Yes_____	High Blood Pressure	Yes	Yes_____
Retinal Disease	Yes	Yes_____	Asthma	Yes	Yes_____
Blindness	Yes	Yes_____	Emphysema	Yes	Yes_____
Corneal dystrophy	Yes	Yes _____	Stomach Ulcer	Yes	Yes_____
Eyes turn In or Out	Yes	Yes_____	Arthritis	Yes	Yes_____
Amblyopia/Lazy Eye	Yes	Yes_____	Lupus	Yes	Yes_____
Corneal Dystrophy	Yes	Yes_____	Rheumatoid Arthritis	Yes	Yes_____
Iritis	Yes	Yes_____	Migraines	Yes	Yes_____
Eye Trauma	Yes	Yes_____	Multiple Sclerosis	Yes	Yes_____
Diabetes	Yes	Yes_____	Hypo/Hyper Thyroid	Yes	Yes_____
Dry Eye	Yes	Yes_____	High Cholesterol	Yes	Yes_____
Heart Condition	Yes	Yes_____	Sleep Apnea	Yes	Yes_____
Other (list)	Yes	Yes_____	Other (list)	Yes	Yes _____
_____			_____		

Do you currently have any symptoms/conditions in the following areas, EVEN IF CONTROLLED by MEDICATION? If yes, please provide details.

Review of Systems	Yes	No	If Yes, explain:
Chronic fever, unexpected weight loss/gain, fatigue	❑	❑	_____
Cardiovascular (e.g. chest pain, irregular heart beat, high blood pressure)	❑	❑	_____
Ear/nose/throat (e.g. hearing loss, sinus problems, sore throat)	❑	❑	_____
Respiratory (e.g. shortness of breath, wheezing, coughing)	❑	❑	_____
Gastrointestinal (e.g. heartburn, abdominal pain, diarrhea, vomiting)	❑	❑	_____
Genitourinary (e.g. frequent, painful, blood, kidney stones)	❑	❑	_____
Musculoskeletal (e.g. muscle aches, joint pain/swelling, arthritis)	❑	❑	_____
Skin (e.g. rashes, dryness, varicose veins)	❑	❑	_____
Neurological (e.g. headaches, numbness, seizures, stroke, paralysis)	❑	❑	_____
Psychiatric (e.g. depression, anxiety, memory loss, confusion)	❑	❑	_____
Endocrine (e.g. diabetes, thyroid)	❑	❑	_____
Hematologic (e.g. bleeding/bruising tendencies, anemia)	❑	❑	_____

List any medications with dosages, including EYE and over-the-counter supplements:

Medication	Dosage	Medication	Dosage
_____		_____	
_____		_____	
_____		_____	
_____		_____	
_____		_____	

Do you have any allergies to Medications, Food, Anesthesia, Latex, etc...? ❑ **Yes** ❑ **No**

If yes please list _____

_____

_____

Current Occupation: _____ **Marital Status:** Single Married Widowed

Do you live: ❑in own home ❑apartment ❑assisted living ❑nursing home Do you live alone ❑**Yes** ❑**No**

Do you? ❑drive ❑gave up driving ❑never drove

Alcohol use: ❑None ❑Social ❑1-2 per day ❑3-6 per day ❑7+ per day

Tobacco use: ❑Cigarettes ❑Chew ❑Cigar ❑Pipe ❑Daily ❑Occasionally ❑Former smoker ❑Never

Do you use any recreational drugs? ___ Yes ___ No Type:_____

List any surgery you have had, including any EYE surgery, with approximate dates:

_____

_____

_____

_____

Why you are here today? Medicare and many other insurances do not cover an exam for Routine Vision, such as you need to have your glasses updated or you need your drivers license form completed. They may cover exams for blurred or decreased vision if there is an underlying medical reason such as a Cataract. If we are following you for a medical condition such as Diabetes or Glaucoma please list this condition.

Complaint _____ Which Eye ___ Left ___ Right___ Both

_____ How long have you had the problem_____

_____ Is the problem getting __worse __better __same

_____ Do you consider this __Mild __Moderate __Severe

Does anything make it better or worse _____

Complaint _____ Which Eye ___ Left ___ Right___ Both

_____ How long have you had the problem_____

_____ Is the problem getting __worse __better __same

_____ Do you consider this __Mild __Moderate __Severe

Does anything make it better or worse _____

Do you wear? glasses contact lenses Did you bring your contact lenses with you? __Yes __No

Please Bring With You To Appointment - DO NOT MAIL - Thank You