



WELCOME TO OUR OFFICE

NAME _____ DATE _____

ADDRESS _____ CITY _____ ZIP _____

PHONE (DAY) _____ (EVENING) _____ EMAIL _____

DATE OF BIRTH _____ AGE _____ S.S.N. _____

OCCUPATION _____ EMPLOYER _____

EMPLOYER'S PHONE _____ EMPLOYER'S ADDRESS _____

SPOUSE'S NAME _____

OCCUPATION _____ EMPLOYER _____

CHILDREN (NAMES/AGES) _____

HOBBIES OR ACTIVITIES _____

DATE OF LAST VISUAL EVALUATION _____ DOCTOR _____

MAIN REASON FOR TODAY'S VISIT _____

HAVE YOU EVER BEEN TREATED FOR OR DIAGNOSED WITH: crossed eyes, lazy eye, glaucoma, retinal disease, cataracts, eye injury, macular degeneration, other? Please list _____

DO YOU WEAR CONTACT LENSES? YES NO ARE YOU CONSIDERING CONTACT LENSES? YES NO

HOW WERE YOU REFERRED TO OUR OFFICE _____

MEDICAL HISTORY

NAME OF MEDICAL DOCTOR _____ DATE OF LAST MEDICAL EXAM _____

LIST MEDICATIONS _____

LIST ANY MAJOR SURGERIES, HOSPITALIZATIONS, OR INJURIES _____

LIST ANY DRUG ALLERGIES _____

ARE YOU PREGNANT OR NURSING? YES NO

FAMILY HISTORY

Please list any parents, grandparents, siblings, children, aunts or uncles that have been diagnosed with the following conditions:

GLAUCOMA _____ CATARACTS _____

CANCER _____ BLINDNESS _____

DIABETES _____ HEART DISEASE _____

LUPUS _____ HIGH BLOOD PRESSURE _____

THYROID DISEASE _____ MACULAR DEGENERATION _____

OTHER _____

SOCIAL HISTORY

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? No Yes If yes, do you have visual difficulty when driving? No yes If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type / amount / how long: _____

Do you drink alcohol? No Yes If yes, type / amount / how long: _____

Do you use illegal drugs? No Yes If yes, type / amount / how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES
Constitutional	<input type="checkbox"/>	<input type="checkbox"/>
Fever, Weight Loss / Gain		<input type="checkbox"/>
Integumentary (Skin)	<input type="checkbox"/>	<input type="checkbox"/>
Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Headaches		<input type="checkbox"/>
Migraines		<input type="checkbox"/>
Seizures		<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision		<input type="checkbox"/>
Blurred Vision		<input type="checkbox"/>
Distored Vision / Halos		<input type="checkbox"/>
Loss of Side Vision		<input type="checkbox"/>
Double Vision		<input type="checkbox"/>
Dryness		<input type="checkbox"/>
Mucous Discharge		<input type="checkbox"/>
Redness		<input type="checkbox"/>
Sandy or Gritty Feeling		<input type="checkbox"/>
Itching		<input type="checkbox"/>
Burning		<input type="checkbox"/>
Foreign Body Sensation		<input type="checkbox"/>
Excess Tearing / Watering		<input type="checkbox"/>
Glare / Light Sensitivity		<input type="checkbox"/>
Eye Pain or Soariness		<input type="checkbox"/>
Chronic Infection of Eye or Lid		<input type="checkbox"/>
Sties or Chalazion		<input type="checkbox"/>
Flashes or Floaters in Vision		<input type="checkbox"/>
Tired Eyes		<input type="checkbox"/>
Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands		<input type="checkbox"/>

SYSTEM	NO	YES
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>
Allergies / Hay Fever		<input type="checkbox"/>
Sinus Congestion		<input type="checkbox"/>
Runny Nose		<input type="checkbox"/>
Post-nasal Drip		<input type="checkbox"/>
Chronic Cough		<input type="checkbox"/>
Dry Throat / Mouth		<input type="checkbox"/>
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>
Asthma		<input type="checkbox"/>
Chronic Bronchitis		<input type="checkbox"/>
Emphysema		<input type="checkbox"/>
Vascluar / Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes		<input type="checkbox"/>
Heart Pain		<input type="checkbox"/>
High Blood Pressure		<input type="checkbox"/>
Vascular Disease		<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea		<input type="checkbox"/>
Constipation		<input type="checkbox"/>
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>
Genitals / Kidney / Bladder		<input type="checkbox"/>
Bones / Joints / Muscles	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis		<input type="checkbox"/>
Muscle Pain		<input type="checkbox"/>
Joint Pain		<input type="checkbox"/>
Lymphatic / Hematologic	<input type="checkbox"/>	<input type="checkbox"/>
Anemia		<input type="checkbox"/>
Bleeding Problems		<input type="checkbox"/>
Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain. _____

I UNDERSTAND THAT ALL CHARGES ARE TO BE PAID AT THE TIME SERVICES ARE RENDERED OR PRIOR TO ORDERING MATERIALS. I AM RESPONSIBLE FOR ANY CHARGES NOT COVERED BY MY INSURANCE. IF YOU ARE COVERED BY INSURANCE WE WILL COMPLETE THE NECESSARY FORMS FOR YOUR REIMBURSEMENT.

Signature _____ C.D.L. # _____ Expiration _____

Doctor's Signature _____ Date _____