



Total Vision Care Optometry

WELCOME TO OUR OFFICE

NAME _____ DATE _____

ADDRESS _____ Apt.# _____ CITY _____ ZIP _____

PHONE (Day) _____ (Evening) _____ CELL _____

EMAIL _____ DATE OF BIRTH _____ AGE _____

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

Constitutional YES NO

- Fever, Weight Loss / Gain

Integumentary (Skin) YES NO

Neurological YES NO

- Headaches
- Migraines
- Seizures

Eyes YES NO

- Loss of Vision
- Blurred Vision
- Distorted Vision / Halos
- Loss of Side Vision
- Double Vision
- Dryness
- Mucous Discharge
- Redness
- Sandy or Gritty Feeling
- Itching
- Burning
- Foreign Body Sensation
- Excess Tearing / Watering
- Glare / Light Sensitivity
- Eye Pain or Soreness
- Chronic Infection of Eye or Lid
- Sties or Chalazion
- Flashes or Floaters in Vision
- Tired Eyes

Endocrine YES NO

- Thyroid / Other Glands

Allergic / Immunologic YES NO

SYSTEM

Ears, Nose, Mouth, Throat YES NO

- Allergies / Hay Fever
- Sinus Congestion
- Runny Nose
- Post-nasal Drip
- Chronic Cough
- Dry Throat / Mouth

Respiratory YES NO

- Asthma
- Chronic Bronchitis
- Emphysema

Vascular / Cardiovascular YES NO

- Diabetes
- Heart Pain
- High Blood Pressure
- Vascular Disease

Gastrointestinal YES NO

- Diarrhea
- Constipation

Genitourinary YES NO

- Genitals / Kidney / Bladder

Bones / Joints / Muscles YES NO

- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

Lymphatic / Hematologic YES NO

- Anemia
- Bleeding Problems

Psychiatric YES NO

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