

W E L C O M E T O O U R O F F I C E

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Name _____ Mr. Mrs. Ms. Dr. (circle one) Date ____/____/____

Address _____ Phone _____

City _____ State _____ Zip _____ Work Phone _____

Email Address _____ Cell Phone _____

Guardian/Spouse (if applicable) _____ Occupation _____

Birthdate ____/____/____ Age _____ Employer _____

Do you have medicare? No Yes Last Eye Exam ____/____/____

Do you have vision insurance? No Yes If yes, insurance carrier _____

Do you have health insurance? No Yes If yes, insurance carrier _____

What is the purpose of today's visit? _____

Are you experiencing any of the following: Distance Blur Reading Blur Eyestrain

Do you work at a computer for long periods? Yes / No Do you have problems with nighttime glare? Yes / No

Are you interested in contact lenses? Yes / No Would you like information on Lasik? Yes / No

How did you hear about us? Friend / Relative / Another Healthcare Practitioner / Internet site*

Medical History *Please specify (i.e. Google, Yellow Pages, Yelp, etc): _____

Do you have any allergies to medication? _____

List medications you take (including oral contraceptives, aspirin, over-the-counter medications, and home remedies)

List all major injuries, surgeries, and/or hospitalizations you have had _____

List any of the following that you have had – crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease, eye infections, eye injury, lasik, or PRK _____

Are you pregnant and/or nursing? No Yes

Do you wear glasses? No Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? No Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Extended Wear Other Are they comfortable? No Yes

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/Condition	No	Yes	?	Relationship
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Over please →

Social History – This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I prefer to discuss my Social History information directly with the doctor.

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 _____

Review of Systems

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

	No	Yes	?		No	Yes	?
Constitutional							
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Mouth, Throat			
				Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures / Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Respiratory			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Styes or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic/Hematologic			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/Immunologic			
Non-Insulin Dependent Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insulin Dependent Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Hormonal Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

If you answered yes to any of the above, or have a condition not listed, please explain and list medications:

May we have permission to obtain records from your previous doctor? Yes / No

Patient (or parent) signature _____