ADVANCED EYECARE

WELCOME TO OUR OFFICE

Dr. Douglas D. Hand • Dr. Michelle Stalzer
Optometrists

(PLEASE PRINT)

Name _____ Today's Date _____ Date of Last Exam_____

Street _____ Date of Birth _____Age_____

City _____ State_____ Zip_____ Sex: M F Social Security # _____

Home Phone _____ Work Phone_____ Spouse (or Parents' Names) _____

Employer (or School) _____ Spouse's (or Parents' Work) Phone _____

Occupation (or Grade) _____ Vision Insurance: _____

FAMILY HEALTH HISTORY

(check each someone in your family has had)

_____ DIABETES
_____ HEART CONDITION
_____ HIGH BLOOD PRESSURE
_____ BLINDNESS
_____ GLAUCOMA
_____ LAZY EYE
_____ AGE RELATED MACULAR DEGENERATION

CURRENT MEDICATIONS

_____
_____
_____
_____

PATIENTS HEALTH HISTORY

(Check each you have had)

_____ BLACKOUTS
_____ CANCER
_____ DIABETES
_____ HEART CONDITION
_____ HIGH BLOOD PRESSURE
_____ THYROID CONDITION
_____ MIGRAINE HEADACHES
_____ BLINDNESS
_____ CATARACTS
_____ POOR COLOR VISION
_____ GLAUCOMA
_____ LAZY EYE
_____ CURRENTLY PREGNANT
_____ OTHER

PATIENTS VISUAL SYMPTOMS

(check each you have had)

_____ DISTANCE VISION BLURRED (WITH GLASSES/CONTACTS)
_____ NEAR VISION BLURRED (WITH GLASSES/CONTACTS)
_____ RECENT CHANGE IN VISION
_____ LIGHT SENSITIVITY
_____ DOUBLE VISION
_____ TEMPORARY LOSS OF VISION
_____ SEE FLASHING LIGHTS
_____ SEE FLOATERS OR SPOTS
_____ EYE STRAIN
_____ HEADACHES RELATED TO EYES
_____ LOSS OF SIDE VISION
_____ DRY EYES
_____ RED EYES

Are you allergic to any medications? ☐Yes ☐ No If Yes, which ones? _____

Do you have any other allergies? ☐Yes ☐ No If Yes, which ones? _____

Alcohol Use

____ daily ____ weekly
____ rarely ____ never

Tobacco Use

____ daily ____ weekly
____ rarely ____ never

What is the major purpose of this visit?

_____

Are you having any problems with your present glasses or contacts?

_____

Are you interested in contact lenses? _____ ☐Yes ☐ No

Have you ever worn or are currently wearing contact lenses? What kind?_____

What contact lens solutions are you using?_____

Do you suffer from dry eyes? ☐Yes ☐ No

Are you interested in sunglasses? ☐Yes ☐ No

Do you have any other hobby, recreational, or occupational visual needs?_____

What other family members are Advanced EyeCare patients?_____

Who may we thank for referring you to our office?_____

Notice of privacy procedures has been reviewed _____