



Date: _____

Email Address: _____

Name: _____ M F

Phone: _____

Address: _____

Work Phone: _____

City: _____ Zip: _____

Last Eye Exam: mm/yy _____

Social Security #: _____

Name of Medical Doctor: _____

Birth Date: _____

Medical Dr.'s Phone #: _____

Your Profession: _____

Last Medical Exam: mm/yy _____

MEDICAL HISTORY

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury:

Do you have any allergies to medications? yes no If yes, explain: _____

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

Do you wear glasses (including readers)? yes no How frequently do you wear them? _____

Do you wear contact lenses? yes no How frequently do you wear them? _____

Are you pregnant and/or nursing? yes no

* Would you like a contact lens prescription with this exam? yes no

Have you worn them before? yes no

If you answered "yes", what is your current contact lens information?

Brand: _____ Base Curve (BC): _____ Powers: _____

** Please note, there are additional fees above and beyond the usual and customary fee for a routine eye examination to provide you with a lens prescription, even for current wearers. These fees are not applicable to most major insurances.*

Do you drive? yes no

If yes do you have visual difficulty when driving? yes no

If yes, please describe: _____

FAMILY HISTORY

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

DISEASE/CONDITION	YES	NO	?	RELATIONSHIP TO YOU
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment/Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crossed Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other (such as lupus etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____



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.

Do you use tobacco products? yes no If yes, type, amount, how long?

Do you drink alcohol? yes no If yes, type, amount, how long?

Do you use illegal drugs? yes no If yes, type, amount, how long?

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

REVIEW OF SYSTEMS

Items marked with a * are of the most importance.

SYSTEM EYES

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

GENERAL

Fatigue/Fever

EAR/NOSE/THROAT

- Chronic cough
Dry Mouth
Sinus Congestion

CARDIOVASCULAR

- Heart Disease
High Cholesterol
High Blood Pressure (hypertension)
Vascular disease

SYSTEM RESPIRATORY

- Asthma
Bronchitis
Emphysema

GENITAL/KIDNEY/BLADDER

Genital, Kidney or Bladder problems

MUSCLES/BONES/JOINTS

Rheumatoid Arthritis

GASTROINTESTINAL

- Crohn's Disease
IBS (Irritable bowel syndrome)

SKIN

- Eczema
Itching
Rosacea

NEUROLOGICAL

- Headaches
* Migraines
Multiple Sclerosis
Numbness
Seizures

PSYCHIATRIC

- ADHD
Anxiety
Depression

ENDOCRINE

- *Diabetes
Hyperthyroid or Hypothyroid

BLOOD/LYMPH

- Anemia
Bleeding Disorders

ALLERGIC/IMMUNOLOGIC

Seasonal Allergies

If you have a condition not listed, please explain:

Doctors Initials: Date: