Name:_____**Date of Birth**:____/____/_____

Address:_____ **Social Security #**:_____

_____ **Occupation**:_____

Marital Status: Single Married Widowed Separated **Employment Status**: FT PT Self Retired Student

Race: American Indian/Alaska Native Asian Black/African American Pacific Islander White

Ethnicity: Hispanic Not Hispanic

Home Phone:_____ **Cell Phone**:_____

Email Address:_____

Please mark your preferred contact information:

□Postal □Cell Phone (Text messages only) □Telephone □Email

Please list your Primary Care Physician or Family Doctor's Office or Specialist

_____

Emergency Contact Person:_____**Phone**:_____

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

If not referred, how did you choose our office? □Another Dr._____

□Saw sign/building □Internet Search □Google □Facebook □Yelp

□Newspaper Ad □Other:_____

PLEASE MARK ALL THAT APPLY TO YOU. THIS INCLUDES ANYTHING YOU ARE BEING TREATED FOR, OR HAVE A HISTORY OF.

PAST OCULAR HISTORY: □**NONE**

□Lazy Eye □Astigmatism □Cataracts □Diabetic Retinopathy □Dry Eye □Glaucoma □Iritis

□Retinal Disease □Other:_____

OCULAR SURGERIES: □**NONE**

□Cataract □Corneal Transplant □LASIK □Eyelid

□Eye Muscle □Retinal □Other:_____

Approximate date of your last eye exam:_____**Name of Previous Eye Doctor**:_____

If you wear contact lenses, list the name and prescription here:_____

YOUR MEDICATIONS: List everything including over-the-counter medications and vitamins. List your dosage and usage. We will copy a list from your doctor if you have one with you.

□No medications taken

_____
_____
_____
_____

MEDICATION ALLERGIES & REACTIONS: □I am not allergic to medications

_____

PLACE A MARK NEXT TO THE SURGERY YOU HAD IN THE PAST:

□Heart Bypass □Carotid Surgery □Cancer_____ □Neurological

DIABETIC PATIENT SECTION Last visit to your doctor_____Next visit with your doctor_____

HgA1c_____(usually between 4-12) Fasting Blood Sugar_____(usually 70-175 or higher)

Have you had Nutritional Counseling? □Yes □No Have you had a Podiatry (Foot) Exam? □Yes □No

SOCIAL HISTORY:

Smoking: □Currently □Former □Never

Alcohol Use: □None □Social Use □Dependency

Drug Use: □None □Recreational Use □Dependency

Sexually Transmitted Disease: □AIDS □Chlamydia □Gonorrhea □HIV □Syphilis

Currently Pregnant: □Yes □No If yes, expected due date_____

Approximate Height:_____ **Approximate Weight**:_____

Have you had a Hearing Screening in the last 5 years? □Yes □No

Would you like a free Hearing Screening? □Yes □No

FAMILY HISTORY: (List only your parents, siblings, and grandparents in the space provided next to the condition)

□I have no family history of these conditions □Unknown (adopted)

□Blindness_____ □Cancer_____ □Diabetes_____

□Glaucoma_____ □Heart Disease_____ □Lazy Eye_____

□Macular or Retinal Disease_____ □Stroke_____

Other:_____

Who requested your visit today? □Doctor Requested □Patient Requested

Please tell us the reason for your visit today:_____

Mark all of the NEW symptoms you would like the doctor to address with you TODAY:

Routine Vision

□I want new glasses

□I want new sunglasses

□I want LASIK

□I want new contacts

Medical Related

□Bloodshot eyes □Dry Eyes □Floaters

□Discharge from eyes □Itching □Flashes

□Headaches □Eye Pain □Double Vision

□Watery eyes □Light Sensitive □Blurry

□Gritty Feeling □Glare/Halos □Eye Strain

LIFESTYLE QUESTIONS:

□I work at a computer for _____hours a day.

□I have difficulty driving at night time.

□My contacts are comfortable all day long.

□I want thinner and lighter glasses.

□I enjoy outdoor activities.

□I have difficulty seeing in low light conditions.

□I use my tablet, smartphone, etc. _____ hours a day.

□My vision is clear at arms length distance.

□I have prescription sunglasses.

□I want to change the color of my eyes.

□My eyewear/contacts work in every situation.

I participate in the following? (Mark all that apply)

□ Golf □ Fishing/Boating/Sailing □ Racquet Sport/Tennis □ Baseball/Softball □ Basketball/Football

□ Skiing/Snowboarding □ Sewing/Needlepoint □Play a Musical Instrument □ Other _____

Please choose the statement(s) you think most accurately reflects your style image most of the time.

□ Fashion Confused.

□ Comfort & vision are all I care about in eyewear.

□ I rarely update my wardrobe or change my look.

□ Fashion Conscious/Curious

□ I believe eyewear should reflect my image.

□ Fashion Cutting Edge

□ I value and recognize quality brands.

□ I consider eyewear just a medical device.

□ I prefer classic, traditional styles.

□ I am not really influenced by fads or trends.

□ I consider my eyewear a fashion/accessory item.

□ I believe my eyewear should make a statement.

□ I am willing to take risks with my overall look.

Patient Initials_____ **Date**_____

REVIEW OF SYSTEMS

Place a mark next to every condition you are taking medication for, or are experiencing today at this visit. If you do not have any conditions listed in the category, please mark the NONE in the category.

CONSTITUTIONAL □None

□Weight loss

□Weight gain

□Excess Thirst

INTEGUMENTARY □None

□Rosacea

□Psoriasis

□Ezcema

□Skin Cancer

GASTROINTESTINAL □None

□Diarrhea

□Constipation

□Reflux Disease

□Hepatitis_____

□Colon Cancer

PSYCHIATRIC □None

□Dementia

□Depression

□Alzheimer's

□Bipolar

□Mentally Challenged

□Attention Disorder

□Anxiety

□Learning Disability

EAR,NOSE, THROAT □None

□Hearing Loss

□Dizziness

□Dental Disorder

RESPIRATORY □None

□Bronchitis

□COPD

□Lung Cancer

□TB

MUSCULOSKELETAL □None

□Rheumatoid Arthritis

□Fibromyalgia

□Osteoporosis

□Gout

□Arthritis

NEUROLOGICAL □None

□Headaches

□Migraines

□Parkinson's Disease

□Brain Tumor

ENDOCRINE □None

□Diabetic Type 1

□Diabetic Type 2

□Hyper Thyroid

□Hypo Thyroid

CARDIOVASCULAR □None

□High Blood Pressure

□Elevated Cholesterol

□Pacemaker

GENITOURINARY □None

□Kidney Disease

□Prostate Cancer

□Bladder Infection

HEMATOLOGIC/LYMPHATIC □None

□Anemia

□Lupus

□Leukemia

□Easily bruised

□Blood Clots

Patient Initials_____ Date_____