

Special Note to our current patients:

Please fill out the "reason for visit" section. Other sections on this page need your attention only if you have any changes or new information in your ocular or systemic health and history. Thank you for your assistance.

REASON FOR VISIT

What brings you to our office today?

Are you having any difficulties with your vision/eyes? If so, explain:

Are you currently experiencing any of the following?

- Eye itching, Burning, Tearing Y/N
- Dry Eyes Y/N
- Double Vision Y/N
- Eye Pain, Eye Strain, Or Fatigue Y/N
- Flashes of Light in Vision Y/N
- Floater in Vision Y/N
- Headaches Y/N

Do you have any special vision (i.e. sports, music, hobbies) that you would like the Doctor to be aware of? If so, explain:

OCULAR HISTORY

Date of Last Eye Exam:

Doctor:

Do you wear glasses? Y/N
For: Distance/Near/Computer/Other

Do you wear contacts? Y/N
If no, would you be interested in wearing contacts?

Are you interested in Laser Vision Correction? Y/N

Have you had any of the following:

- Eye Surgery Y/N
If Yes Explain:
- Eye Injury/Head Injury/Stroke Y/N
If Yes Explain:
- Eye Disease Y/N
If Yes Explain:

MEDICAL HISTORY

Date of Last Medical Exam:

Doctor:

General Health: Excellent/Good/Fair/Poor

Do you have problems in any of the following areas?

- Allergies, Immune System Y/N
- Sinus, Ears, Nose, Throat Y/N
- Respiratory (Lungs, Breathing, TB) Y/N
- Cardiovascular (Heart, Blood Press) Y/N
- Stomach, Colon Y/N
- Neurological (Seizure, MS) Y/N
- Bones, Joints, Arthritis, Muscles Y/N
- Hepatitis Y/N
- Endocrine (Diabetes, Thyroid) Y/N
- Skin Y/N
- Blood, HIV/AIDS Y/N
- Behavioral, Depression Y/N
- Cancer Y/N

Please Explain: _____

Current Condition:

- Cigarette/Tobacco use? Y/N
- Alcohol use? Y/N
- Other substance(s)? Y/N
- Are you pregnant? Y/N

Please list your current medications and why you are taking them:

Do you have any allergies to medications? Y/N
(Please indicate the medication and the reaction that occurs)

FAMILY HISTORY

Does anyone in your family have problems in the following areas? If yes, who?

- Cataracts Y/N
- Glaucoma Y/N
- Macular Degen. Y/N
- Retinal Problems Y/N
- Blindness Y/N
- Lazy/Wandering Eye Y/N
- Diabetes Y/N
- High Blood Pressure Y/N
- Cardiovascular Y/N
- Respiratory Y/N
- Neurological Disease Y/N
- Arthritis Y/N
- Cancer Y/N

Doctor Signature:

Date: