WELCOME TO OUR OFFICE

Reason for today's visit: _____
_____

If you wear glasses, when do you wear them? _____

Please answer the following questions by circling a number:

	Never 0	Slight 1	Moderate 2	Severe 3
Gritty or sandy sensation?	0	1	2	3
Pain or soreness?	0	1	2	3
Fluctuating vision?	0	1	2	3
Occasional tearing?	0	1	2	3
Blurred vision while reading?	0	1	2	3
Discomfort in windy conditions?	0	1	2	3
Discomfort in air-conditioned areas?	0	1	2	3
Itching?	0	1	2	3

Please circle Yes (Y) or No (N):

Distance vision blurry without glasses	Y	N
Distance vision blurry with glasses	Y	N
Near vision blurry without glasses	Y	N
Near vision blurry with glasses	Y	N
Headaches	Y	N
Sinus problems	Y	N
Flashes of light	Y	N
Floaters	Y	N
Loss of vision (blackout)	Y	N
Eye pain	Y	N
Double vision	Y	N
Eye injuries	Y	N
Eye surgeries	Y	N
Eyes cross	Y	N
Lazy eye	Y	N
Other (please explain)	Y	N

_____
_____

	You		Family	
Diabetes	Y	N	Y	N
High blood pressure	Y	N	Y	N
Heart problems	Y	N	Y	N
Breathing problems	Y	N	Y	N
Cataracts	Y	N	Y	N
Glaucoma	Y	N	Y	N
Macular degeneration	Y	N	Y	N
Cancer	Y	N	Y	N

Please list all medications and the reasons you are taking them:

_____
_____
_____
_____
_____

Do you consume alcohol?	Y	N	If yes, how many drinks per week? _____
Do you use recreational drugs?	Y	N	If yes, how many times per week? _____
Do you consume tobacco products?	Y	N	If yes, how many packs per day? _____
Do you have any drug or environmental allergies?	Y	N	If yes, please explain:

_____
_____

Signature _____ Date _____

DR. HOWARD B. STROMWASSER

OPTOMETRIST

VISUAL FIELDS EXAMINATION

A highly specific computerized instrument allows us to provide a more thorough medical analysis of your eyes. Our HUMPHREY VISUAL FIELDS ANALYZER electronically measures retinal function and sensitivity to light. This measurement can assist us in the early detection of many disorders, including brain tumors, glaucoma, diabetic retinopathy, and retinal detachments.

We strongly recommend that all of our patients receive the screening version of this exam. It is especially important for people who have:

1) Headaches
2) See spots or flashes of light
3) A history of Diabetes
4) A history of high blood pressure
5) Circulatory problems
6) A strong eyeglass prescription
7) Reached age of 35

There is an additional charge of $20.00 for the screening exam.

Please check the appropriate line below and sign at the bottom.

_____ I DO want the visual field exam

_____ I DO NOT want the visual field exam

PATIENT'S SIGNATURE _____

DATE: _____