Rev 1-2008

Type of Insurance: ☐ Private ☐ Medicare ☐ VSP ☐ MES ☐ Medical ☐ Healthy Families ☐CHDP/CMSP ☐Other _____

Today's Date_____ Rev 6/2006

Last Name_____ First Name_____ MI ___ Date of Birth ____/____/____ Age_____

Address_____ City _____ State _____ Zip _____

Social Security # _____ Home Phone _____Other Phone ☐Cell ☐ Work _____

Employer/School_____ Occupation Or School Grade_____

Home E-Mail: _____Work E-Mail: _____

Parent/Guardian or Care Taker's Name_____ Phone # (if different from above)_____

Personal Physicians Name & Address _____

Do You Wear Glasses? ☐ Yes ☐ No They are Used ☐ For Distance Only ☐ For Near Reading Only ☐For Both Far & Near

Your Last Exam Was Approximately _____ Years Ago Your Current Glasses Are Approximately _____ Years Old

The Reason For Your Visit Today Is: ☐ I am Having Problems With My Vision and/or The Health of My Eyes

☐ Other (Please Explain) _____

Personal History: IF YOU ARE HAVING PROBLEMS SEEING OR WITH HEALTH OF YOUR EYE PLEASE INDICATE YOUR PROBLEMS

Mark Any Box That Applies to <u>Your Eyes Only</u>

☐ Blurred Distance Vision	☐ Loss of Central Vision	☐ Itchy Eyes
☐ Blurred Near Vision	☐ Loss of Side Vision	☐ Distorted Vision or Wavy Vision
☐ Headache	☐ Double Vision	☐ Sandy or Gritty Sensation of the Eyes
☐ Redness of the Eye	☐ Mucous Discharge	☐ Pain or Soreness in or Around the Eye
☐ Dry Eye	☐ Crossed Eyes	☐ Flashing Lights or Floaters
☐ Watery Eyes	☐ Tired Eyes	☐ Eyestrain
☐ Foreign Body Sensation	☐ Problems with Glare	☐ Significant Light Sensitivity

☐ Other _____

Family History: Have You or Any of Your Close Family Members (mom, dad, brothers or sisters) Have Had Any Of The Following Problems:

☐**None of the problems below apply to myself or my immediate family.**

☐ Blindness or Loss of Vision	☐ Glaucoma (High Eye Pressure)	☐ Migraine Headache	☐ Cancer Type_____
☐ Cataracts	☐ Macular Degeneration	☐ Retinal Detachment	☐ Kidney Disease
☐ High Blood Pressure	☐ Diabetes	☐ Multiple Sclerosis	☐ Heart Disease
☐ Thyroid Disease	☐ Amblyopia or Lazy Eye	☐ Color Vision Problems	
☐ Any Eye Surgery	☐ Any Other Eye Disease or Injury_____		

Social History: Do You Smoke? ☐ Yes ☐ No # of Packs Per Day _____ Do You Drink? ☐ Yes ☐ No ☐Occasionally ☐ Daily

Do You Have Hobbies? ☐Yes ☐ No _____

Do You Play Sports? ☐ Yes ☐ No What Type_____

REVIEW OF SYSTEMS: Please Mark the Box If You Ever Had or Currently Have Any Of the Following Problems

☐ None ☐ Yes **Allergic/Immunologic**: drug allergy, rheumatoid arthritis, lupus, histoplasmosis, sarcoid, HIV
☐ None ☐ Yes **Cardiovascular** : heart disease, high blood pressure, heart attack, stroke, heart surgery, cholesterol
☐ None ☐ Yes **Constituional**: developmental disability, weight loss, fever, fatigue, trauma
☐ None ☐ Yes **Ears, Nose & Throat:** upper respiratory infection, sinus congestion, hearing loss
☐ None ☐ Yes **Endocrine:** diabetes, thyroid dysfunction, hormonal dysfunction,gout
☐ None ☐ Yes **Gastrointestinal:** ulcer, digestive disorder, colitis, Crohn's disease, liver disease
☐ None ☐ Yes **Genitourinary:** kidney/bladder disorder, sexually transmitted disease,ovarian/uterine disease, prostate
☐ None ☐ Yes **Hematologic/Lymphatic:** leukemia, anemia, blood loss, temporal arteritis
☐ None ☐ Yes **Integumentary:** skin disease, eczema, psoriaisis, rosacea, dermatitis
☐ None ☐ Yes **Muskuloskeletal:** muscular dystrophy, fibromyalgia, osteoarthritis, anlylosing spondylitis
☐ None ☐ Yes **Neurologic:** multiple sclerosis, epilepsy, migraines, seizures, brain disorder, Bell's Palsy
☐None ☐ Yes **Psychiatric:** depression, panic disorder, schitzophrenia, ADD
☐None ☐ Yes **Respiratory:** asthma, chronic bronchitis, emphysema, TB, COPD

If You Are Diabetic Are You Taking ☐ Oral Medication (pills) ☐ Insulin Type & Dosage ☐ No Medication Diet Control Only

Please List Your Diabetic Medication _____

Are You Taking Any Prescription Medication ? ☐ Yes ☐ No (If Yes Please Indicate the Problem by Checking the Box Below)

☐ High Blood Pressure	☐ High Cholesterol	☐ Heart Problems	☐ Arthritis	☐ Steroids for Inflamation
☐ Asthma	☐Allergies	☐ Sleeping Pills	☐ Depression	☐Antibiotics for Infection
☐ Psychiatric/Mental Disease		☐ Other_____		