General Information

Date: ____/____/____

Last Name_____ First Name_____ MI____ DOB:____/____/____

M or F SSN:____/____/____ Spouse:_____ DOB:____/____/____

Address:_____ City:_____ State:_____ Zip:_____

Home Ph:( )_____ Work Ph:( )_____ Cell Ph:( )_____

Emergency Contact: _____ Relation:_____ Phone#:( )_____

Employer/School:_____ Occupation/School Grade:_____

Email Address:_____ Sports/Hobbies:_____

I have received or was offered and declined a notice of privacy practices.
Date _____ ***Signature*** _____

I understand that I am responsible for services not covered by Insurance.
_____
signature of responsible party

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:____/____/____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:_____ Replace Schedule:_____

Have you ever had eye injuries? Yes No Which Eye?_____

Have you ever had eye surgeries? Yes No Why?_____

Have you taken eye medication? Yes No Why?_____

Have you ever been diagnosed with?

Cataracts: Yes No When were you diagnosed?_____

Glaucoma: Yes No When were you diagnosed?_____

Macular Degeneral Yes No When were you diagnosed?_____

Please circle and explain any of the following past or present conditions that apply:

Blurred Vision - Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision - Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

Are you currently pregnant or nursing? Yes No

Notes:

OPTOMETRIC CONSULTING

*** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE***

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other: ___ Medications_____	**Endocrine:** ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other: ___ Medications:_____	**Respiratory:** __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other: Medications:_____
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other: ___ Medications:_____	**Genitourinary:** __ None ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other: ___ Medications:_____	**Psychiatric:** __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other: ___ Medications:_____
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other: ___ Medications:_____	**Musculoskeletal:** __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other: ___ Medications_____	**Immunologic:** __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other: ___ Medications:_____
Hematological: __ None ___ Anemia ___ Leukemia ___ Other: ___ Medications:_____	**Gastrointestinal:** __ None ___ Crohn's ___ Colitis ___ Other: ___ Medications_____	**Ear/Nose/Throat:** __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other: ___ Medications:_____
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other: ___ Medications_____	**Allergies** (please list) __ None Drug: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

_____

_____

_____

_____

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) ever been diagnosed with:

DISEASE / CONDITION

Blindness:	Yes	No	Who?_____
Cataracts:	Yes	No	Who?_____
Glaucoma:	Yes	No	Who?_____
Crossed Eyes:	Yes	No	Who?_____
Macular Degeneration:	Yes	No	Who?_____
Retinal Detachment:	Yes	No	Who?_____
High Blood Pressure:	Yes	No	Who?_____
Diabetes:	Yes	No	Who?_____
Cancer:	Yes	No	Who?_____
Heart Disease:	Yes	No	Who?_____
Thyroid Disease:	Yes	No	Who?_____

Who referred you to our clinic: Family Friend Yellow Pages Other (List)_____

Reviewed by:

Dr _____ Date_____