

Patient Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Doctor you are seeing today: _____

Reason for today's visit: _____

Do you have any specific questions for your doctor today? _____

Are you planning to get new eyeglasses today? Y / N

If not a contact lens wearer, are you interested in trying contacts today? Y / N

Are you interested in learning more about Laser Vision Correction? Y / N

Contact Lens History:

Do you currently wear contact lenses? Y / N Hours per day: _____ Days per week: _____

Brand or prescription you are currently wearing? _____ Today's wearing time: _____

If not wearing contacts now, have you tried them in the past? Y / N Reason for stopping? _____

Glasses History:

Do you currently wear glasses? Y / N (Circle One) Part-time Full-time Distance Near

Glasses being worn now: (Circle One) Single Vision Bifocals Progressive Trifocals

Do you wear sunglasses: Y / N Are your sunglasses your most recent prescription? Y / N

Social History:

Employer: _____ Occupation: _____

Do you have any hobbies that require special glasses or contacts? _____

Use of Alcohol: None ___ Social use only ___ 1-2 drinks daily ___ Above average use ___ Alcohol Dependence ___

Use of Tobacco: None ___ Former Smoker ___ Light Smoker ___ Average Smoker ___ Heavy Smoker ___

Use of Narcotic: None ___ Type & frequency _____

Sexually Transmitted Disease: None ___ Yes ___ HIV Positive ___

Current Medications

1. _____ for _____ 6. _____ for _____

2. _____ for _____ 7. _____ for _____

3. _____ for _____ 8. _____ for _____

4. _____ for _____ 9. _____ for _____

5. _____ for _____ 10. _____ for _____

Drug Allergies: Y / N Please list: _____

Ocular History

Please list all Ocular Surgeries:

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

Procedure: _____ Year: _____ Which Eye?: _____ Dr. _____

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Current Eye Symptoms/Conditions					
Headaches	Yes	Excess Tearing/Watering	Yes	Blurred Distance Vision	Yes
Glare/Light Sensitivity	Yes	Eye Pain/Soreness	Yes	Blurred Near Vision	Yes
Tired Eyes	Yes	Sandy/Gritty Feeling	Yes	Fluctuating Vision	Yes
Amblyopia/Lazy Eye	Yes	Foreign Body Sensation	Yes	Glaucoma	Yes
Burning	Yes	Mucous Discharge	Yes	Cataracts	Yes
Dryness	Yes	Distorted Vision/Halos	Yes	Retinal Detachment	Yes
Itching	Yes	Loss of Side Vision	Yes	Macular Degeneration	Yes
Redness	Yes	Floaters/Spots	Yes		
Indicate any personal history below:					
Cardiovascular		Integumentary		Musculoskeletal	
Congestive Heart Failure	Yes	Acne Rosacea	Yes	Arthritis	Yes
Elevated Cholesterol	Yes	Lupus	Yes	Rheumatoid Arthritis	Yes
High Blood Pressure	Yes	Psoriasis	Yes	Neurological	
Stroke	Yes	Dizziness	Yes	Bell's Palsy	Yes
Endocrine		Head/ENT/Dental		Brain Tumor	
Diabetes	Yes	Chronic Cough	Yes	Multiple Sclerosis	Yes
Gout	Yes	Migraines	Yes	Parkinson's Disease	Yes
Thyroid (High or Low)	Yes	Sinusitis	Yes	Seizures	Yes
Renal Disease (Kidney)	Yes	Dizziness	Yes	Psychiatric	
Gastrointestinal		Hematologic/Lymphatic		Alzheimer's	
Cancer: Colon, Liver.	Yes	Leukemia	Yes	Bi-Polar Disorder	Yes
Colitis	Yes	Lymphatic Disorder	Yes	Depression	Yes
Hepatitis	Yes	Sickle Cell Disease	Yes	Learning Disability	Yes
Inflammatory Bowel Disease	Yes	Temporal Arthritis	Yes	Schizophrenia	Yes
Genitourinary		Immunologic		Respiratory	
Menopause	Yes	AIDS	Yes	Asthma	Yes
Prostate Cancer	Yes	Sarcoidosis	Yes	COPD	Yes
Cervical Cancer	Yes	Sjogren's Syndrome	Yes	Emphysema	Yes
Breast Cancer	Yes	Syphilis	Yes	Lung Disorder	Yes
		Tuberculosis	Yes	Lung Cancer	Yes

Family Physician:

Name _____ Address _____ Phone: _____

Family History:

		Relationship to Patient		Relationship to Patient	
Amblyopia/Lazy Eye	Yes		Cancer	Yes	
Blindness	Yes		Diabetes	Yes	
Cataracts	Yes		Heart Disease	Yes	
Glaucoma	Yes		Stroke	Yes	
Retinal Detachment	Yes		Thyroid Disease	Yes	
Macular Degeneration	Yes		Other	Yes	

Doctor: C, L, S, CC **Patient's Name** _____ **Date:** _____

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