

Patient Information

Patient Name _____ Today's Date _____

Birth Date _____ Social Security # _____ Male Female

Address _____ Home Phone _____

City _____ State _____ Zip Code _____

Check Appropriate Box: Minor Single Married Divorced Widowed Separated

Patient's or Parent's (if patient is a minor) Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent's (if patient is a minor) Name _____ Employer _____ Work Phone _____

If patient is a student, name of school/college _____ City _____ State _____

Person to contact in case of an emergency _____ Phone Number _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____

Insurance Information

Name of Insurance Company _____

Name of Insured _____ Relationship to Patient _____

Social Security #/ ID # _____ Birthdate _____

Employer _____

Secondary Insurance _____

Vision History

Last Eye Exam _____ Dr's Name _____ City&State _____

Do you currently wear Glasses Contacts Both

When do you wear them All the time Reading Driving TV Computer Work

Have you ever had any of the following eye conditions?

	Yes	No	?		Yes	No	?		Yes	No	?
Sandy or Gritty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluctuating Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/ Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Distorted Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drooping Eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

Do you drive? Yes No If yes, do you have visual difficulty when driving? No Yes If yes, please describe: _____

Do you use tobacco products? No Yes If yes, type/amount/ how long: _____

Do you drink alcohol? No Yes If yes, type/amount/ how long: _____

Do you use illegal drugs? No Yes If yes, type/amount/how long: _____

Medical History

Name of Primary Care Physician _____ Phone Number _____

Last Medical Exam _____

Do you have any allergies to medications? No Yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

List any major injuries, surgeries and/or hospitalizations you have had in the last five years: _____

Review of Systems: (Please indicate any personal history below)

	Yes	No	?		Yes	No	?		Yes	No	?
Constitutional				Respiratory				Musculoskeletal			
Good general health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain or cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ears/ Nose/ Throat				Gastrointestinal				Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Earaches or drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic sinus problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic/ Immunologic			
Mouth sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to:			
Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful bowels	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath or bad taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rectal bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Narcotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss or injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric				Pain remedies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological				Memory loss/confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus antitoxin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antiseptics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heamtologic/Lymphatic			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light headed or dizzy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular				Bleeding tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Convulsions or seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Slow to heal after cut	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Past transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Shortness of breath,							
				while walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				while lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
				Swelling of feet, ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				or hands							

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

Disease/ Condition	No	Yes	?	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____