Optometric Consulting

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:_____

E-mail Address: _____ Sports/Hobbies: _____

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/Sometimes/Work Only/Reading only/Driving only

Do you wear contacts? Yes No Type:_____

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

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

Have you used eye medication? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms: Please circle any 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
Eye Pain/Soreness	Wandering eye	Droopy Lid	Sandy/Gritty Feeling
Tired eyes	Mucus Discharge		

Notes:

Confidential

Please turn 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:	**Endocrine:** ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Genitourinary:** __ None ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other:	**Psychiatric:** __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ None ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal:** __ None ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**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) :

1 _____	**For** _____	**2** _____	**For** _____
3 _____	**For** _____	**4** _____	**For** _____
5 _____	**For** _____	**6** _____	**For** _____
7 _____	**For** _____	**8** _____	**For** _____
9 _____	**For** _____	**10** _____	**For** _____

Please Describe your allergic reaction: _____

_____

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

DISEASE / CONDITION

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

Reviewed by:

Dr _____ Date _____

 Revised 3/22/06