



Your eyes are special, Your eyecare should be too

First Name:	Last Name:	Date of Birth:
_____	_____	_____
Social Security Number:	Gender	
_____	_____	
Address:	City:	Zip Code:
_____	_____	_____
Phone Number:	Email:	
_____	_____	
Medical Insurance:	Vision Insurance:	Policy Holder: Name & Birthdate
_____	_____	_____

**CHIEF COMPLAINT**

Please select all that apply:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> LOSS OF VISION | <input type="checkbox"/> FLASHES OF LIGHT     | <input type="checkbox"/> LIGHT SENSITIVITY |
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> EYE PAIN/SORENESS    | <input type="checkbox"/> TIRED EYES        |
| <input type="checkbox"/> DOUBLE VISION  | <input type="checkbox"/> WATERY EYES          | <input type="checkbox"/> DRY EYES          |
| <input type="checkbox"/> FLOATERS       | <input type="checkbox"/> SANDY/GRITTY FEELING | <input type="checkbox"/> RED EYES          |
| <input type="checkbox"/> CROSSED EYES   | <input type="checkbox"/> GLARE                | <input type="checkbox"/> BURNING/ITCHING   |

Other (please explain):

**HISTORY OF PRESENT ILLNESS**

Location: Which eye has the problem?    Quality: How is it affecting you?    Severity: How severe is the problem?

Duration: How long has it been going on?    Timing: Is it new, ongoing, or returning?    Context: Associated with:

Modifiers: Previous treatment? (drops, medication, ect.)    Symptoms: Are there associated symptoms (ex:headache)

**FAMILY HISTORY**

Has anyone in your family been diagnosed with:  
(select all that apply)

- Diabetes
- High Blood Pressure
- Cancer

Has anyone been diagnosed with any of the following eye  
problems: (select all that apply)

- Glaucoma
- Macular Degeneration
- Amblyopia
- Strabismus (eye turn)
- Cataracts

**SOCIAL HISTORY**

Do you smoke? If so, how much?

Do you consume alcohol? If so, how much on average per week?

**CURRENT VISION**

Do you currently wear glasses?

Do you currently wear contact lenses?

What type of contacts do you wear? Do you know the powers? How often do you replace your contact lenses?

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REVIEW OF SYSTEMS: PLEASE SELECT ALL THAT APPLY TO YOUR CURRENT HISTORY

**Ocular/Eye :**

- Inflammatory disorder
- Surgery
- Glaucoma
- Amblyopia (lazy eye)
- Cataract
- Retinal problems
- Macular degeneration
- Strabismus (eye turn)
- Patching

Other (please explain):

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**Constitutional :**

- Cancer
- N/A
- Fatigue
- Developmental disability

Other (please explain):

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**Ears, Nose, Throat, Mouth :**

- Laryngitis
- Sinusitis
- Dry mouth
- N/A
- Hearing Loss

Other (please explain):

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**Neurological:**

- Cerebral Palsy
- Epilepsy
- Multiple Sclerosis
- N/A
- Tumor

Other (please explain):

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**Psychiatric:**

Other explanation --

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**Cardiovascular :**

- Vascular disease
- Heart disease
- Stroke
- High blood pressure
- Congestive heart failure
- N/A

Other (please explain):

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**Gastrointestinal Problems :**

- Colitis
- N/A
- Chron's disease
- Ulcer

Other (please explain):

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**Genitourinary :**

- Prostate disease/cancer
- N/A
- STD
- Kidney disease

Other (please explain):

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**Musculoskeletal :**

- Ankylosis spondylitis     
  Fibromyalgia     
  Muscular dystrophy  
 Osteoarthritis     
  N/A

Other (please explain):

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**Skin :**

- Rosacea     
  Psoriasis     
  Eczema  
 N/A

Other (please explain):

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**Endocrine :**

- Insulin dependent diabetes     
  Hormonal dysfunction     
  Thyroid dysfunction  
 Non-insulin diabetes     
  N/A

Other (please explain):

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**Blood/Lymph :**

- Large volume blood loss     
  Anemia     
  N/A

Other (please explain):

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**Allergy/Immunologic :**

- Environmental allergies     
  Rheumatoid arthritis     
  Drug allergies  
 Lupus     
  N/A

Other (please explain):

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List any medicine allergies :

List any other allergies:

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**Current Medications**

Please list all other medications you are currently taking:

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**SURVEY TO BETTER SERVE YOU**

Are your eyes sensitive to sunlight?

- Yes  No

Interested in newer contact lens technology?

- Yes  No

Problems with reflections and/or glare?

- Yes  No

Want a non-surgical option to LASIK?

- Yes  No

Please list your sporting activities/hobbies:

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Do you work at a computer?

- Yes  No

Want information on thinner/lighter lenses?

- Yes  No

Want information on LASIK vision surgery?

- Yes  No

Do you spend time outdoors?

- Yes  No