



PATIENT NAME: _____ DATE: _____

ACCOUNT NO: _____

Chief Complaint

How can we help you today? In this space please briefly tell us any signs and symptoms you are experiencing. (Medical insurance will only cover if there is a medical reason for the exam such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, glaucoma, cataracts, floaters, dry eyes.)

Ocular History

Are you having any problems with your current contact lenses or glasses? Explain _____

When was your last eye exam? _____ Who was the doctor? _____

Do you wear glasses? Yes ___ No ___ How old are they? _____

Do you wear contact lenses? Yes ___ No ___ What kind? _____

How old are your contact lenses? _____ Do you sleep in them? _____

Medical History

List any medications you take and for what illness (including aspirin, oral contraceptives, over the counter meds, home remedies etc.)

Do you have any allergies to medications? Yes ___ No ___ Which _____

Past History

List all major injuries, surgeries and/or hospitalizations _____

Family Medical/Eye History (Check all that apply)

Is there a family medical history of any of the following?

- | | Relationship |
|----------------------|--------------------------------|
| Blindness | <input type="checkbox"/> _____ |
| Cataracts | <input type="checkbox"/> _____ |
| Corneal Problems | <input type="checkbox"/> _____ |
| Glaucoma | <input type="checkbox"/> _____ |
| Eye Surgery | <input type="checkbox"/> _____ |
| Lazy Eye | <input type="checkbox"/> _____ |
| Macular Degeneration | <input type="checkbox"/> _____ |
| Color blindness | <input type="checkbox"/> _____ |
| Retinal Problems | <input type="checkbox"/> _____ |
| Crossed eyes | <input type="checkbox"/> _____ |
| Diabetes | <input type="checkbox"/> _____ |
| Heart Disease | <input type="checkbox"/> _____ |
| High blood pressure | <input type="checkbox"/> _____ |
| Arthritis | <input type="checkbox"/> _____ |
| Thyroid | <input type="checkbox"/> _____ |
| Cancer | <input type="checkbox"/> _____ |
| Other | <input type="checkbox"/> _____ |

Review or Systems-Do you have a problem with...

Eyes	Y	N	Allergic/Immunologic	Y	N	Hematologic/lymphatic	Y	N
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	Medicine allergies	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	Dry throat/mouth	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Chronic ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Breast	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eyes	<input type="checkbox"/>	<input type="checkbox"/>	Constitutional symptoms			Musculoskeletal		
Flashes/floaters	<input type="checkbox"/>	<input type="checkbox"/>	Heart pain	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Watery eyes	<input type="checkbox"/>	<input type="checkbox"/>	Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain	<input type="checkbox"/>	<input type="checkbox"/>
Red eyes	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine			Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Burning/itching	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Mucous discharge	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty all the time	<input type="checkbox"/>	<input type="checkbox"/>	Neurological		
Sandy/gritty feeling	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain/ soreness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Glare/light sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	Other problems	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
Chronic eye infection	<input type="checkbox"/>	<input type="checkbox"/>	Other glands	<input type="checkbox"/>	<input type="checkbox"/>	Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>
Tired eyes	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			Depression	<input type="checkbox"/>	<input type="checkbox"/>
Halos	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Compulsive behavior	<input type="checkbox"/>	<input type="checkbox"/>
Vision Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory		
Eye surgery	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Eye injury	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Retinal detachment	<input type="checkbox"/>	<input type="checkbox"/>	Genitals	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
			Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	Lung Cancer	<input type="checkbox"/>	<input type="checkbox"/>
			Bladder	<input type="checkbox"/>	<input type="checkbox"/>			

Social History

This is confidential and may be discussed directly with the doctor if so desired.

Do you use any of the following products?

Past or Current Activities

Tobacco Yes ___ No ___
 Alcohol Yes ___ No ___
 Illegal Drugs Yes ___ No ___

Have been exposed to or infected with?

Gonorrhea Yes ___ No ___
 Hepatitis Yes ___ No ___
 HIV Yes ___ No ___
 Syphilis Yes ___ No ___

Doctor Signature _____ Date _____