Patient Information

Name_____________________________________ Today's Date____________

Address ____

City _________________ State _____ Zip_________

Cellular Phone ____________________ Home Phone____________________

Work Phone____________________

Date of Birth______/_______/______ Male _____ Female _____

Single____ Married____ Divorced____ Widowed____ Separated____

Spouse's Name (If applicable) ____

Party Responsible For Patient Account

Name of person responsible for this account_____________________________

Relationship to Patient________________ Home Phone___________________

Address ____

City _________________ State _____ Zip_________

Emergency Contact

Name_________________________________ Relationship ________________

Address ____

City _________________ State _____ Zip_________

Cellular Phone __________________ Home Phone__________________

Work Phone__________________

Insurance Information

Please bring your insurance cards to your appointment so we can make copies of them to keep on file.

Social/Visual Function Hx. Ocular Hx.

Do you have any allergies to medications? Y N If yes, please list and explain:

____

Do you wear glasses? ____ Yes ____ No

Contact Lenses? ____ Yes ____ No

Have you had cataract surgery? ____ Yes ____ No

Have you had other operations within the last year? _____ If yes, what type and

when? ____

Do you Drive? _____________

Family History: Please note any family history, parents, grandparents, siblings, children (Living or deceased):

	NO	YES	RELATIONSHIP TO YOU
High Blood Pressure	□	□	________________________________
Macular Degeneration	□	□	________________________________
Diabetes	□	□	________________________________
Retinal Detachment	□	□	________________________________
Glaucoma	□	□	________________________________
Cataracts	□	□	________________________________
Other Eye Conditions	□	□	________________________________

Previous low vision care: Yes____ No____ If yes, when and where?

____

OCULAR HISTORY: (surgeries, laser or other treatments, eye medications)

____

Has your vision changed significantly in the past months?

____

Does your vision fluctuate from day to day? Yes____ No ____

Living Situation (alone, spouse, children, nursing home, assisted living)____

Other limitations (difficulty walking, tremors, etc.)

____

Previous Optical Devices used____

FOR PHYSICIAN'S USE
Reviewed: Date and Initial
____
____
____
____
____
____

Review of Systems and Medical History

Do you currently, or have you ever had any problems in the following areas? Please check YES or NO.

CONSTITUTIONAL	**NO**	**YES**
Weight Gain/Loss		
Fatigue		
Problems with Sleep		
NEUROLOGICAL		
Headaches		
Migraines		
Seizures		
Dizziness/balance		
Memory		
Processing Difficulties		
Concentration		
CVA/(Stroke)		
EYES		
Blurred Vision		
Distorted Vision/ Halos		
Loss of Side Vision		
Double Vision		
Dryness		
Mucous Discharge		
Redness/Irritated		

EYES, Continued	NO	YES
Sandy or Gritty Feeling		
Itching/Burning		
Excess Tearing/Watering		
Eye Pain/Soreness		
Chronic Eye Infections		
Sties or Chalazion		
Flashes/Floaters in Vision		
Cataracts		
Glaucoma		
Macular Degeneration		
Eye Injury		
ENDOCRINE		
Thyroid/Other Glands		
Diabetes		
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever		
Runny Nose/Post-Nasal Drip		
Hearing Sensitivity		
Chronic Cough		
Dry Mouth/Throat		
Imbalance		
Ringing/Noise in ears		
RESPIRATORY		
Asthma		
Chronic Bronchitis		
Emphysema		
VASCULAR/CARDIOVASCULAR		
Heart Problems		
High Blood Pressure		
Vascular Disease		
GENITOURINARY		
Genitals/Kidney/Bladder		
BONES/JOINTS/MUSCLES		
Arthritis		
Body Pain		
LYMPHATIC/HEMATOLOGIC		
Anemia		
Bleeding Problems		
PSYCHIATRIC		
Depression		
Anxiety		
Mood Swings		

If you answered, “YES” to any of the above questions or have a condition that is not listed, please explain:

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