Name:_____ Date: _____

1) Eye related history:

(Please circle yes or no whether you have, had, or use)

Cataracts	yes/no
Cataract surgery	yes/no
Laser eye surgery	yes/no
Glaucoma	yes/no
Macular degeneration	yes/no
Diabetic retinopathy	yes/no
Corneal disorders	yes/no
Retinal disorders	yes/no
Retinal surgery	yes/no
Dry eyes	yes/no
Plugs for dry eyes	yes/no
Injury in/around eyes	yes/no
Eyelid surgery	yes/no
Prescription eye drops	yes/no
Nonpresc. drops	yes/no
Eye specific vitamins	yes/no
Prescription sunglasses	yes/no
Contact lenses	yes/no
Eyeglasses for distance	yes/no
Eyeglasses for reading	yes/no
Eyeglasses for computer	yes/no

2) List your medication below:

(or we can copy your list)

_____

_____

_____

_____

_____

_____

_____

3) List your eye drops below:

_____

_____

_____

4) Review of systems: (Circle any that apply)

Constitution	developmental disabilities, cancer, fatigue syndrome
Ear nose and throat	dry mouth, hearing loss, sinusitis, laryngitis
Neuro	multiple sclerosis, epilepsy, tumor, migraine, stroke, cerebral palsy
Psych	bipolar disorder, attention deficit, depression, anxiety disorder
Cardio	stroke, vascular disease, congestive heart failure, hypertension, heart disease
Respiratory	cigarette smoker, chronic obstruction, bronchitis, sleep apnea, asthma, emphysema
Stomach/intestinal	acid reflux, colitis, ulcer, Crohn's disease
Genital/urinary	pregnant, benign prostate hypertrophy, prostate disease/cancer, kidney disease, nursing
Musculo-skeletal	arthritis, osteoarthritis, ankylosing spondylitis, gout, muscular dystrophy, osteoporosis, fibromyalgia
Skin	eczema, psoriasis, shingles, cold sores, rosacea
Endocrine	hormonal dysfunction, type II diabetes, type I diabetes, thyroid dysfunction
Blood	anemia, ulcer, elevated cholesterol, large volume blood loss
Allergy	rheumatoid arthritis, Sjogren's syndrome, environmental allergies, drug allergies, lupus

***Turn over for page 2 please ***

5) Medication allergies (please list) _____

6) Family History: (circle any of the following that your blood related family members have or had):

glaucoma, macular degeneration, lazy eye, retinal detachment, diabetes, high blood pressure, thyroid disorders, cancer

7) Social History: Do you currently smoke tobacco ? yes/no Have you ever smoked? yes/no
Do you consume alcohol yes/no Quantity? (optional)

8) Primary Care Physician: Name: _____
Location: city and state _____

9) Symptoms: (Circle any that apply and we will discuss in detail)

Blurry vision at distance (ie trouble seeing street signs, golf ball, ball scores on television, other)

Blurry vision at near (reading, sewing, hobbies, working , other)

Blurry vision at intermediate distances (computer work, price tags at stores,)

Halos, starbursts, or elongations around lights at night

Double vision at near or far, constant or intermittent, with only one eye or both eyes open, new or old

Floaters right and/or left eye, new or old, appear as dots/lines/webs/see-through curtains, one/several/many

Flashes right and/or left eye, new or old, duration brief or for several minutes

Dryness new or old, constant or intermittent, attempts at treatment?

Excess tearing new or old, constant or intermittent, one or both eyes, attempts at treatment?

Pain

Vision loss permanent or transient

10) Eyeglasses information:
Are you planning on changing your eyeglasses today? Y/N/ or possibly
Do you have prescription sunglasses? Y/N
How many care of prescription eyeglasses do you use regularly including prescription sunglasses, reading , computer, _____
Have you tried progressive lenses? Y/N Have you ever had any problems adjusting to progressive lenses or new eyeglasses? Y/N
Have you tried antireflective coating? Y/N
Have you tried polarized lenses? Y/N
Do you have special eyeglasses that you use for the computer, golf , TV, or reading? Y/N

11) Contact lens information: (Circle any that apply and we will discuss in detail)
Average wearing time ___ hours/day or ___ days if you wear them continuously
Today's wearing time:___ hours/day or ___ days if you wear them continuously
Average number of days per week you wear contact lenses _____
Disinfecting and cleaning solutions used _____
Replacement schedule ____ days
Type or brand of contact lenses: _____

12) Person or party responsible for payment today: self-pay, Medicare, Blue Cross Blue Shield, Vision Service Plan, Tri-care, other please list: _____