

Date: _____

Name: _____ DOB: _____

Email Address: _____

- Do you wear glasses/contact lenses for:**
- distance (driving, television, sports events)
 - intermediate (computer, shopping, sheet music)
 - near (reading, needlepoint)

Are you satisfied with the clarity of your vision with current glasses/contacts?

- Yes
- No, please explain _____

Are you experiencing any of the following: (check all that apply)

- Blurred vision
- Redness
- Burning
- Itching
- Eye strain
- Eye pain
- Tearing
- Discharge
- Headaches
- Flashes
- Floaters
- Double vision
- Severe sensitivity to lights
- Bothersome glare
- Dry Eye
- Poor night vision
- Total loss of vision
- Other _____

Please list ALL current medications, supplements, and vitamins (including dosage) Or Attach List

Primary Care Physician/Clinic: _____ **Date of last exam** _____

Interests: (check all that apply)

- New eyeglasses
- Reading glasses
- Prescription sunglasses
- Safety glasses
- Non-prescription sunglasses
- New supply of contact lenses
- Computer glasses
- New fitting of contact lenses
- Sports (including hunting, swimming, motorcycle)

Review of Systems (check all that apply):

(Constitution) developmental disabilities cancer fatigue Syndrome

(ENT) hearing loss sinusitis dry mouth laryngitis

(Neurologic) multiple sclerosis epilepsy cerebral palsy tumor stroke/CVA migraine,
 autism spectrum disorder

(Psychiatric) depression attention deficit anxiety bipolar disorder

(Cardiovascular) **hypertension** stroke/CVA heart disease vascular disease
 congestive heart failure

(Respiratory) cigarette smoker asthma bronchitis emphysema chronic obstruction
 sleep apnea

(GI) Crohn's colitis ulcer acid reflux celiac disease

(GU) kidney disease prostate disease/cancer STD (herpetic/Chlamydia),
 benign prostate hypertrophy herpes Chlamydia **pregnant/nursing (_____delivery date)**

(Musculoskeletal) osteoarthritis arthritis fibromyalgia muscular dystrophy
 ankylosing spondylitis osteoporosis gout

(Integumentary) eczema rosacea psoriasis herpes simplex (cold sores) herpes zoster (shingles)

(Endocrine) **type 2 diabetes mellitus** **type 1 diabetes mellitus** thyroid dysfunction
 hormonal dysfunction

(Hematic/Lymphatic) anemia large volume blood loss ulcer **high cholesterol**

(Allergy/Immune) **drug allergies** **environmental allergies** rheumatoid arthritis lupus,
 Sjogren's syndrome

Family Medical History: (check all that apply)

Cancer Diabetes Hypertension High Cholesterol Hyperthyroidism Hypothyroidism

Family Ocular History: (check all that apply)

Amblyopia Cataract Macular Degeneration Glaucoma Retinal Detachment Strabismus

Social History:

• Alcohol Use: Never Occasional Daily

• Tobacco Use: Never Previous Current

▪ Tobacco Type_____ How often_____