

**Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Doctor you are seeing today: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Do you have any specific questions for your doctor today? \_\_\_\_\_

When was your last eye exam? \_\_\_\_\_ What doctor did the exam? \_\_\_\_\_

**Are you planning on getting new eyeglasses today? Y / N**

**Do you wear contact lenses? Y / N Are you planning on getting contacts today? Y / N**

**Are you interested in learning more about Laser Vision Correction? Y / N**

### **Contact Lens History:**

Do you currently wear contact lenses? Y / N Hours worn per day: \_\_\_\_\_ Hours worn today: \_\_\_\_\_

How often do you throw away your lenses? \_\_\_\_\_ Do you sleep in your contacts? Y / N

Current brand: \_\_\_\_\_ Prescription you are wearing: \_\_\_\_\_

How old is your current pair of contacts? \_\_\_\_\_ What solution do you use? \_\_\_\_\_

### **Glasses History:**

Do you currently wear glasses? Y / N (Circle one) Part-time Full-time Distance only Near only

If you currently wear glasses, how old are your lenses? \_\_\_\_\_

What type of lenses? Single Vision Bifocals Progressives Trifocals

### **Social History:**

Do you have any hobbies or does your occupation require special glasses or contacts? \_\_\_\_\_

Use of Alcohol: \_\_\_None \_\_\_Social use only \_\_\_1-2 drinks daily \_\_\_Above average use \_\_\_Alcohol dependence

Use of Tobacco: \_\_\_None \_\_\_Former smoker \_\_\_Light smoker \_\_\_Average smoker \_\_\_Heavy smoker

Use of Narcotics: \_\_\_None \_\_\_Type & frequency \_\_\_\_\_

Do you drive? Y / N

### **Current Medications**

Please list the name or what condition the medication is for:

1. \_\_\_\_\_ 6. \_\_\_\_\_

2. \_\_\_\_\_ 7. \_\_\_\_\_

3. \_\_\_\_\_ 8. \_\_\_\_\_

4. \_\_\_\_\_ 9. \_\_\_\_\_

5. \_\_\_\_\_ 10. \_\_\_\_\_

**Drug Allergies: Y / N Please list:** \_\_\_\_\_

### **Ocular History**

Please list all eye related surgeries or injuries:

Procedure/Injury: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: \_\_\_\_\_ Dr. \_\_\_\_\_

Procedure/Injury: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: \_\_\_\_\_ Dr. \_\_\_\_\_

Procedure/Injury: \_\_\_\_\_ Year: \_\_\_\_\_ Eye: \_\_\_\_\_ Dr. \_\_\_\_\_

**PLEASE FILL OUT BOTH SIDES OF THIS FORM**

Indicate any personal history below:									
Cardiovascular			Integumentary			Musculoskeletal			
Congestive Heart Failure	No	Yes	Acne Rosacea	No	Yes	Arthritis	No	Yes	
Elevated Cholesterol	No	Yes	Lupus	No	Yes	Rheumatoid Arthritis	No	Yes	
High Blood Pressure	No	Yes	Psoriasis	No	Yes	Neurological			
Stroke	No	Yes	Dizziness	No	Yes	Bell's Palsy	No	Yes	
Endocrine			Head/ENT/Dental			Brain Tumor			
Diabetes	No	Yes	Chronic Cough	No	Yes	Multiple Sclerosis	No	Yes	
Gout	No	Yes	Migraines	No	Yes	Parkinson's Disease	No	Yes	
Thyroid (high or low)	No	Yes	Sinusitis	No	Yes	Seizures	No	Yes	
Renal Disease (kidney)	No	Yes	Dizziness	No	Yes	Psychiatric			
Gastrointestinal			Hematological/Lymphatic			Alzheimer's			
Cancer: Colon, Liver	No	Yes	Leukemia	No	Yes	Bi-Polar Disorder	No	Yes	
Colitis	No	Yes	Lymphatic Disorder	No	Yes	Depression	No	Yes	
Hepatitis	No	Yes	Sickle Cell Disease	No	Yes	Learning Disability	No	Yes	
Inflammatory Bowel Disease	No	Yes	Temporal Arthritis	No	Yes	Schizophrenia	No	Yes	
Genitourinary			Immunologic			Respiratory			
Menopause	No	Yes	AIDS/HIV	No	Yes	Asthma	No	Yes	
Prostate Cancer	No	Yes	Sarcoidosis	No	Yes	COPD	No	Yes	
Cervical Cancer	No	Yes	Sjogren's Syndrome	No	Yes	Emphysema	No	Yes	
Breast Cancer	No	Yes	Syphilis	No	Yes	Lung Disorder	No	Yes	
			Tuberculosis	No	Yes	Lung Cancer	No	Yes	

Please list any major systemic surgeries:

1. \_\_\_\_\_ Year: \_\_\_\_\_
2. \_\_\_\_\_ Year: \_\_\_\_\_

**Family Physician:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Family History:											
<input type="checkbox"/> I am adopted and do not know my family history											
			Relative						Relative		
			(If Grandparent, please specify Maternal or Paternal)						(If Grandparent, please specify Maternal or Paternal)		
Lazy Eye	No	Yes		Cancer (type _____)	No	Yes					
Eye Turning	No	Yes		Diabetes	No	Yes					
Blindness	No	Yes		Heart Disease	No	Yes					
Cataracts	No	Yes		Stroke	No	Yes					
Glaucoma	No	Yes		Thyroid Disease	No	Yes					
Retinal Detachment	No	Yes		High Blood Pressure	No	Yes					
Macular Degeneration	No	Yes		Other	No	Yes					

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