

WELCOME TO OUR OFFICE!

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

Please Print

Date _____	Marital Status <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W
Patient's Full Legal Name _____	Spouses Name _____
DOB ____/____/____ SSN# ____/____/____	DOB ____/____/____ SSN# ____/____/____
Address _____	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other
City/St _____ Zip _____ Country _____	Special Needs: <input type="checkbox"/> Hearing Impaired <input type="checkbox"/> Translator <input type="checkbox"/> Wheelchair
Type of Address <input type="checkbox"/> Home <input type="checkbox"/> Office	Race <input type="checkbox"/> White <input type="checkbox"/> African American <input type="checkbox"/> Asian
Home Phone _____	<input type="checkbox"/> Other _____ <input type="checkbox"/> Decline to Answer
Cell Phone _____	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino
Work Phone _____	<input type="checkbox"/> Unknown <input type="checkbox"/> Decline to Answer
Email _____	Employer _____ Occupation _____
	Last PCP Visit ____/____/____ PCP Doctor _____
	Last Eye Exam ____/____/____
	Prev. Eye Dr. _____

Note: It is now required we obtain an email address so we can upload your visit to the patient portal

Miscellaneous

List any previous surgeries with dates _____ _____	Do you wear glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you interested in contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you interested in refractive surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are You Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you perform fine or close-up work? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are You Breastfeeding? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you outdoors all or part of the time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hobbies/Recreational Sports you enjoy _____	Do you have trouble reading signs when driving at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you bothered by glare from: Overhead lighting? <input type="checkbox"/> Yes <input type="checkbox"/> No
	A computer screen? <input type="checkbox"/> Yes <input type="checkbox"/> No
How many hours per day do you use a computer? _____	Oncoming headlights at night? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you sensitive in bright sunlight? <input type="checkbox"/> Yes <input type="checkbox"/> No

Review of Systems

Do you currently have, or have you ever had, any of the following problems or conditions?

	Yes	No		Yes	No		Yes	No
Constitutional			Gastrointestinal			Neurological		
Fever, Weight Loss/Gain <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular			Crohn's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer / Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric		
Vascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Genito-Urinary			Anxiety / Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Ears/Nose/Mouth/Throat			Bladder / Genital / Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Simplex <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Prostate <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type II <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskeletal			Thyroid/Other Glands <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Joint / Muscle Pain <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic - Hematologic		
Dry Mouth/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Osteo Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory			Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Integumentary (skin)			Allergic / Immunologic		
Chronic Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Eczema <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Hives <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Herpes Zoster/Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	Lupus <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>
						Organ transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>

Ocular History

(mark yes or no to each question)

Age-related macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	Injury to the eye region	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amblyopia (Lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Keratoconus	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness-one eye	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retinopathy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blindness-both eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus (Crossed eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tear film insufficiency (dry eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other _____	
History of refractive surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

Patient's Past Medical History

(mark yes or no to each question)

Acquired Immune Deficiency Syndrome (AIDS)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Human immunodeficiency virus infection (HIV)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypercholesterolemia (high cholesterol)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypertensive disorder (Hypertension)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal allergy	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic obstructive lung disease (COPD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid dysfunction	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Family Health History

(mark yes or no to each entry. If yes, list which family member including mother, father, brother, sister, maternal/paternal grandmother or maternal/paternal grandfather)

Amblyopia (Lazy eye)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Strabismus (cross eyes)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Blindness and/or vision impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Cataract	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Macular Degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Hypertension (high blood pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
Retinal disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No _____	Cardiovascular disease	<input type="checkbox"/> Yes <input type="checkbox"/> No _____
		Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No _____

Social History (check one for each question)

Are you a drug user? Yes No

Are you a: Non-drinker Social drinker

Tobacco Use (mark which one applies)

Heavy tobacco smoker Light tobacco smoker

Never a smoker Former smoker

Medications

List all **CURRENT** prescriptions, over-the-counter prescriptions, eye drops and dosages for each.

No Medications

Medication Allergies

List any allergies you may have and reaction.

No Medication Allergies

Tech Initials _____ Date _____

Dr. Signature _____

Tech Initials _____ Review Date _____

Dr. Initial _____

Tech Initials _____ Review Date _____

Dr. Initial _____

Tech Initials _____ Review Date _____

Dr. Initial _____