

**THE EYE EXPERIENCE**

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**PATIENT INFORMATION**

FULL NAME: \_\_\_\_\_ TODAY'S DATE \_\_\_\_/\_\_\_\_/\_\_\_\_  
ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_  
CITY, STATE ZIPCODE: \_\_\_\_\_ CELL: \_\_\_\_\_  
BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ SOCIAL SECURITY #: \_\_\_\_-\_\_\_\_-\_\_\_\_ SEX: \_\_\_\_\_ MALE \_\_\_\_\_ FEMALE  
E-MAIL \_\_\_\_\_ LAST MEDICAL EXAM: \_\_\_\_\_ LAST EYE EXAM: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**PREFERRED METHOD OF CONTACT FOR APPOINTMENT REMINDERS** (Please Circle): Cell Home Phone Email Text Message  
MEDICAL DOCTOR: \_\_\_\_\_ PREVIOUS EYE DR. \_\_\_\_\_  
MARITAL STATUS: \_\_\_\_\_ SPOUSE'S NAME \_\_\_\_\_  
NAMES OF CHILDREN IN LIVING IN YOUR HOUSEHOLD \_\_\_\_\_  
OCCUPATION: \_\_\_\_\_ FULL TIME PART TIME RETIRED STUDENT SCHOOL: \_\_\_\_\_  
EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
VISION INSURANCE \_\_\_\_\_ PRIMARY MEDICAL INSURANCE \_\_\_\_\_  
HOW DID YOU HEAR ABOUT OUR OFFICE? (Please Circle) Insurance website Google Yahoo Walk By Yellow Pages Referral  
WHO MAY WE THANK FOR REFERRING YOU? \_\_\_\_\_

**INSURED PARTY INFORMATION (if self continue to next section)**

INSURED NAME: \_\_\_\_\_ RELATIONSHIP TO PT. \_\_\_\_\_  
INSURED ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_ BIRTH DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_ (insured)  
EMPLOYER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_  
EMPLOYER ADDRESS: \_\_\_\_\_

**MEDICAL HISTORY**

List any medications you take (including oral contraceptives, aspirin, over the counter medications and vitamins): \_\_\_\_\_  
Do you have any environmental allergies or allergies to medications? \_\_\_ YES \_\_\_ NO If yes, please explain: \_\_\_\_\_  
List all major injuries, surgeries and/or hospitalizations: \_\_\_\_\_  
List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infection or eye injury: \_\_\_\_\_  
Do you wear glasses? \_\_\_ YES \_\_\_ NO If yes, how old is your present pair? \_\_\_\_\_  
Do you wear contacts? \_\_\_ YES \_\_\_ NO If yes, what type do you wear? \_\_\_\_\_

**FAMILY HISTORY**

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

*Please turn over and complete the other side*

**SOCIAL HISTORY**

Do you drive?  no  yes If yes, do you have a visual difficulty when driving?  no  yes If yes, please describe:

Do you use tobacco products?  no  yes If yes, what type? Amount? How many years? \_\_\_\_\_  
Do you drink alcohol?  no  yes If yes, what type? Amount? How many years? \_\_\_\_\_  
Do you use illegal drugs?  no  yes If yes, what type? Amount? How many years? \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently or have any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
<b>CONSTITUTIONAL</b>				<b>EARS, NOSE, MOUTH, THROAT</b>			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>INTEGUMENTARY (Skin)</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>NEUROLOGICAL</b>				Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>EYES</b>				<b>RESPIRATORY</b>			
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>VASCULAR / CARDIOVASCULAR</b>			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GASTROINTESTINAL</b>			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>GENITOURINARY</b>			
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>BONES / JOINTS / MUSCLES</b>			
Eye Pain/Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Infection of Eye or Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Stye/Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>LYMPHATIC / HEMATOLOGIC</b>			
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ENDOCRINE</b>				Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Gland Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<b>PSYCHIATRIC</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered YES to any of the above or have a condition not listed, please explain:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Printed Name of Patient or Patient's Representative

Representative's Relationship to Patient

Signature of Patient or Patient's Representative

Date

Doctor's Signature

Date