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| **Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI:\_\_ DOB:\_\_\_/\_\_\_/\_\_\_\_**  **Occupation / Hobbies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician / Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Reason For Today’s Visit:** |

**Tobacco: Yes / No Chew / Cigarettes Alcohol: Yes / No Beer / Wine / Hard Liquor**

**For how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For how long:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you quit how many years ago?\_\_\_\_\_\_\_\_\_ Recreation drug use:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications and/or Vitamins that the Patient is taking**:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Vision Correction: Glasses / Contacts / None**

**Type of Contacts Worn in the Past:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Wear time:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cleaning solution:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical History of Patient: Height\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_**

**General:** Fever/ Weight Loss/ Weight Gain/ Fatigue/ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Ear, Nose, Throat:** Allergies/ Sinus/ Cough/ Dry Mouth/ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Cardiovascular**: Hypertension/ Heart Disease/ Vascular Disease/ Other\_\_\_\_\_\_\_\_\_\_\_\_ **NONE**

**Respiratory**: Asthma/ Bronchitis/ Emphysema/ COPT/ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ **NONE**

**Genital, Kidney, Bladder:** Kidney Stones/ Frequent Urination, Impotence/ Other\_\_\_\_\_\_\_\_\_ **NONE**

**Musculoskeletal**: Osteoarthritis/ Fibromyalgia/ Muscular Dystrophy/ Other \_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Dermatologic**: Eczema/ Rosacea/ Psoriasis/ Other \_\_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Neurological**: Multiple Sclerosis/ Epilepsy/ Cerebral Palsy/ Tumor/ Stroke/ Other \_\_\_\_\_\_\_\_\_\_\_ **NONE**

Headaches/ Migraines/ Seizures

**Psychiatric**: ADHD/ Depression/ Schizophrenia/ Anxiety/ Other \_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Endocrine**: Type 1 Diabetes/ Type 2 Diabetes/ Thyroid Problem/ Other\_\_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Constitutional**: Cancer/ Trauma/ Developmental Disability/ Other \_\_\_\_\_\_\_\_\_\_\_ **NONE** **Ocular**: Glaucoma/ Macu­lar Degeneration/ Detached Retina/ Other\_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Immunological**: AIDS/ HIV/ Rheumatoid Arthritis/ Lupus/ Other \_\_\_\_\_\_\_\_\_\_\_\_ **NONE** **Hematological**: Anemia/ Leukemia/ Cholesterol/ Other \_\_\_\_\_\_\_\_\_\_\_ **NONE** **Gastrointestinal**: Crohns/ Colitis/ Other \_\_\_\_\_\_\_\_\_\_\_\_ **NONE**

**Have you experienced any of these eye symptoms in the last month?**

Fluctuating vision [ ] contact lens discomfort[ ] light sensitivity[ ] watery eyes[ ] Tired eyes[ ] redness [ ] Burning [ ] Itching [ ] Feeling of sand or grit in eye [ ]

**Family History (Blood Relatives)**: Yes / No / (Who)

Cancer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry Eye: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart Disease: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stroke/HTN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataracts: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Arthritis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Eye Injury / Surgery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Notes/ Other Ailments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Reviewed by** Dr\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |