YOU & EYE

VISION CARE AND OPTICAL BOUTIQUE

Welcome to our office – It is our true pleasure to have you here today. We strive to offer patient-centered eye and vision care. Please complete the following to help us get to know you and tailor your exam to your exact needs.

Patient Information

Name: _____ Date of Birth: ____/_____/____ Sex: □ Male □ Female

Address: _____ City: _____ State: ____Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Email Address: _____ Guardian Name (if applicable):_____

Preferred Method of Contact: □ Home Phone □ Cell Phone □Text Message □ Email

Occupation (or Grade): _____ ___ Employer (or School): _____

Insurance Information *(If applicable)*

Subscriber's Name (if different from above): _____Date of Birth: _____/_____/_____
Medical Insurance Carrier: _____
Social Security Number: _____/_____/_____ **OR** Member ID: _____
Vision Care Plan Carrier: _____ Member ID: _____

Ocular History

Last Eye Exam: _____/_____/_____ Do you wear glasses? □ Yes □ No If yes, how old are your present glasses: _____

Do you wear contact lenses? □ Yes □ No If yes, what type: □ RGP □ Soft □ Other If soft, what brand? _____

Have you had refractive surgery? □ Yes □ No If yes, date: _____Type: _____

Do you use a computer? □ Yes □ No If yes, how many hours per day? _____

Are you currently experiencing any of the following problems with your eyes? Check the box if yes.

□ Blurred Vision	□ Flashes / Floaters in Vision	□ Itching
□ Loss of Vision	□ Halos / Glare / Light Sensitivity	□ Redness
□ Loss of Side Vision	□ Dryness	□ Excess Tearing / Watering
□ Distorted Vision	□ Sandy or Gritty Feeling	□ Eye Pain or Soreness
□ Double Vision	□ Burning	□ Mucous Discharge
□ Tired Eyes		

Have you been diagnosed with any of the following? Check the box if yes.

□ Cataracts	□ Glaucoma	□ Retinal Detachment
□ Crossed Eyes	□ Lazy Eye / Amblyopia	□ Dry Eye
□ Eye Injury	□ Macular Degeneration	□ Other_____

Medical History

Medical Doctor: _____ Practice Address: _____ Last Medical Exam: _____/_____/_____

List any medications you are currently taking (include oral contraceptives, aspirin, over the counter medications):

_____

_____

Are you allergic to any medications? □ Yes □ No If yes, which ones? _____

Review of Systems

Constitution □ All Normal
- □ Developmental Disabilities
- □ Cancer
- □ Fatigue Syndrome

Ears, Nose, Mouth, Throat □ All Normal
- □ Hearing Loss
- □ Sinusitis
- □ Dry Mouth
- □ Laryngitis

Neurological □ All Normal
- □ Multiple Sclerosis
- □ Epilepsy
- □ Cerebral Palsy
- □ Tumor
- □ Migraine

Psychiatric □ All Normal
- □ Depression
- □ Attention Deficit
- □ Anxiety Disorder
- □ Bipolar Disorder

Cardiovascular / Cardiac □ All Normal
- □ High Blood Pressure
- □ Stroke/CVA
- □ Heart Disease
- □ Vascular Disease
- □ Congestive Heart Failure

Respiratory □ All Normal
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Obstruction
- □ Sleep Apnea

Gastrointestinal □ All Normal
- □ Crohn's Disease
- □ Colitis
- □ Ulcers
- □ Acid Reflux
- □ Celiac Disease

Genitourinary □ All Normal
- □ Kidney Disease
- □ Prostate Disease/Cancer
- □ STD – Herpetic/Chlamydia
- □ Benign Prostate Hypertrophy
- □ Pregnant/Nursing

Musculoskeletal □ All Normal
- □ Arthritis
- □ Osteoarthritis
- □ Fibromyalgia
- □ Muscular Dystrophy
- □ Ankylosing Spondylitis
- □ Osteoporosis
- □ Gout

Integumentary (Skin) □ All Normal
- □ Eczema
- □ Rosacea
- □ Psoriasis
- □ Herpes Simplex/Cold Sores
- □ Herpes Zoster/Shingles

Endocrine □ All Normal
- □ Type 2 Diabetes Mellitus
- □ Type 1 Diabetes Mellitus
- □ Thyroid Disease

Hematologic / Lymphatic □ All Normal
- □ Anemia
- □ Hypercholesteremia

Allergic/Immune □ All Normal
- □ Environmental Allergies
- □ Rheumatoid Arthritis
- □ Lupus
- □ Sjogren's Syndrome

If you checked any of the above boxes or have a condition not listed, please explain further:

_____

_____

Do you use: Alcohol? □ Yes □ No Tobacco products □ Yes □ No Illicit drugs? □ Yes □ No

Family History

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

	Relation to you		**Relation to you**
□ Cancer	_____	□ Cataract	_____
□ Type I Diabetes	_____	□ Macular Degeneration	_____
□ Type II Diabetes	_____	□ Glaucoma	_____
□ High Blood Pressure	_____		
□ Hyperthyroid Disease	_____		
□ Hypothyroid Disease	_____		

Signature: _____ Date: _____