General History

Date: _____

Name:_____ Name you prefer to be called:_____

Phone #: _____ Date of Birth:_____Age:_____Gender M F Occupation _____

How did you find out about this office?_____ Marital Status **S M W D**

Date of last eye exam:_____Name of previous eye doctor:_____ Your Hobbies _____

Reason for today's visit:_____Number of hours spent on a computer per day:_____

Check if you have any of the following:

O Glare from lights at night O Sensitivity to sunlight O Double vision O Eye Disease O Cataracts O Dry Eyes

O Burning OTearing OItching eyes O Crossed "Turned Eye" O Glaucoma O Floaters O Flashes of Light O Lazy Eye

O Headaches, if yes, How often?_____Location: _____ Duration: _____Do you wake up with them? O Yes O No

Severity: _____ Onset Time of Day: **AM PM** How do you get relief ? _____

Wear contacts? O Yes O No If No, are you interested in contacts?:_____ If Yes, what type/brand do you wear? _____

Hrs worn per day:_____When did you last wear your contacts?_____How old are they?_____

Are you considering laser refractive surgery? O Yes O No

Medical History

Date of your last physical exam: _____Name of physician: _____

List all of the following conditions you have, the year they were first diagnosed, and **all medications you're taking** for each:

Y or N Are you taking any medications? If so, please list them: _____

_____

Y or N Allergies to Medications and other Allergies: _____

Y or N Immune System (AIDS, HIV, Lupus, MS, etc.): _____

Y or N Sinus, Eyes, Ears, Nose: _____

Y or N Respiratory (Lungs, Breathing, T.B., etc.): _____

Y or N Cardiovascular (Heart, High Blood Pressure, etc.):_____

Y or N Stomach, Colon:_____

Y or N Neurological (Seizures, Paralysis, etc.): _____

Y or N Arthritis, Bones, Joints, Muscles: _____

Y or N Hepatitis: _____

Y or N Endocrine (Diabetes, Thyroid, etc.): _____

Y or N Skin Conditions:_____

Y or N Blood (Anemia, Dyscrasias, etc.): _____

Y or N Behavioral (Depression, etc.): _____

Y or N (Women) Pregnant or Breast Feeding: _____

Y or N History of Stroke, Head Injury, or Cancer: _____

Y or N Surgeries/Operations: _____

Do you have now, or have you had WITHIN the PAST YEAR.

(Please indicate with a Yes or No)

Y or N	Joint pains	Y or N	High Blood Pressure	Y or N	Heartburn	Y or N	Changes in weight
Y or N	Swelling of Joints	Y or N	Enlarged Glands	Y or N	Shortness of Breath	Y or N	Changes in skin
Y or N	Frequent Infections	Y or N	Chronic / Frequent Cough	Y or N	Ringing in Ears	Y or N	Anxiety/Sadness
Y or N	Chest pains	Y or N	Recurrent Stomach Pain	Y or N	Sinus Trouble		

Family History: Check if anyone in your family has had any of the following:

O Heart Disease	O Macular degeneration	O Thyroid Disease	O Blindness	O Lazy Eye	O Glaucoma
O Retinal problems	O Neurological Disease	O High blood pressure	O Cataracts	O Arthritis	O Diabetes

Dilation Consent: Dilation of the pupils provides your Dr. with a better view of the tissue and structures inside your eyes; this improved view aids in the diagnosis of eye diseases. Dilation is accomplished by putting eye drops in each eye. The effects usually last several hours. The negative effects include a temporary increased sensitivity to light; some temporary blurring may occur.

____ I'll have the Doctor decide if he/she will dilate my eyes. ____ No, I do not want to have my eyes dilated.

Signature: _____ Date: _____