Family EYEWEAR GALLERY

Office Use Only

Data Entered by _____

Pretesting by _____

Reviewed by Dr. _____

Reviewed by Tech _____

New Patient History

Name: _____ Date of Birth _____ Social Security # _____

What brings you in today? _____

Date of Last Eye Exam _____ by Doctor _____

Primary Care Physician _____ Location _____

Date of Most Recent Physical _____

Do you wear eyeglasses? Y / N

Do you wear contact lenses? Y / N Would you like to ? Y / N
What type do you wear now? Soft RGP Hybrid Toric Multifocal
Brand? _____
How old is the set you are wearing today? _____
Do you wear your lenses overnight while you sleep? Y / N How many days in a row? _____
How often do you replace your lenses? Everyday Every 2 weeks Monthly Yearly
What cleaning system do you use? _____
Do you need to use eye drops during the day for dryness? _____

Do you have any of the following vision concerns?

Blurred Vision	Headache	Total Vision Loss
Eyestrain	Poor Night Vision	Other _____
Eye Pain	Bothersome Night Glare	_____
Severe Light Sensitivity	Double Vision	_____

Do you have any of the following eye concerns?

Redness	Tearing
Burning	Discharge
Itching	Other _____

Have you been diagnosed with any of the following conditions?

Cataract	Nystagmus	Iritis
Macular Degeneration	Diabetic Retinopathy	Retina Defects or Degeneration
Glaucoma	Dry Eyes	Other _____
Diabetes	Eye Infection	_____
Crossed Eyes	Floaters/Flashes	
Keratoconus	Lazy Eye	

Health History

Do you have any of the following health issues? If so, please list any medications you use with dosage.

Constitution: Cancer Weight Gain Weight Loss Chronic Fatigue Other: _____ Meds: _____	**Respiratory:** Cigarette Smoking Asthma Bronchitis Emphysema Chronic Obstruction Sleep Apnea Other: _____ Meds: _____
Ear/Nose/Throat: Hearing loss Sinusitis Dry Mouth Laryngitis Other: _____ Meds: _____	**Gastrointestinal:** Crohn's Disease Colitis Ulcer Acid Reflux Celiac Disease Irritable Bowel Other: _____ Meds: _____
Neurological Issues: Multiple Sclerosis Stroke Migraine Autism Other: _____ Meds: _____	**Genitourinary:** Kidney Disease Prostate Cancer Chlamydia Herpes Benign Prostate Hypertrophy Other: _____ Meds: _____
Psychological: Anxiety Depression Bipolar Attention Deficit Other: _____ Meds: _____	**Reproductive:** Pregnant Nursing

Cardiovascular: Hypertension Stroke Heart Disease Vascular Disease Congestive Heart Failure Other: _____ Meds: _____	**Musculoskeletal:** Arthritis Fibromyalgia Muscular Dystrophy Ankylosing Spondylitis Osteoporosis Gout Other: _____ Meds: _____
Integumetary (Skin): Eczema Rosacea Psoriasis Herpes Simplex (Cold Sores) Herpes Zoster (Shingles) Other: _____ Meds: _____	**Endocrine:** Type 2 Diabetes Type 1 Diabetes Thyroid Dysfunction Hormonal Dysfunction Other: _____ Meds: _____
Blood Disorders: Anemia Blood Loss Ulcer High Cholesterol Other: _____ Meds: _____	**Allergic or Immune:** Drug Allergies Environmental Allergies Rheumatoid Arthritis Lupus Sjogren's Syndrome Other: _____ Meds: _____

Surgical History

Have you had any surgical correction for the following conditions?

Glaucoma or Glaucoma Suspect
Cataract
Macular Degeneration
Patching for Lazy Eye
Inflammatory Disorder
Eye Muscle Surgery
Other _____

Retinal Hole/Tear/Detachment/Degeneration
Keratoconus
Injury
Dry Eye (punctal occlusion)
Nystagmus
LASIK or PRK

Allergies

Do you have any known medication allergies? _____

Do you have any environmental allergies or seasonal allergies? _____

Do you have latex sensitivity? Y / N

Social History

What is your occupation? _____

What are your hobbies? _____

Do you use alcohol products? Y / N How frequently? _____

Do you use any tobacco products? None Cigarettes Cigars Chewing Tobacco
How Frequently? _____

Family History

Please indicate if you have a family history of any of the following in your immediate family (M – mother, F – father, B-brother, S – sister, GP - Grandparent)

Osteoarthritis	F	M	B	S	
Asthma	F	M	B	S	
Thyroid Disorders	F	M	B	S	
Cancer	F	M	B	S	
Type 1 Diabetes	F	M	B	S	
Type 2 Diabetes	F	M	B	S	
Hypertension	F	M	B	S	
Heart Disease	F	M	B	S	
High Cholesterol	F	M	B	S	
Rheumatoid Arthritis	F	M	B	S	
Stroke	F	M	B	S	
Amblyopia	F	M	B	S	GP
Color Blindness	F	M	B	S	GP
Cataract	F	M	B	S	GP
Macular Degeneration	F	M	B	S	GP
Glaucoma	F	M	B	S	GP
Retinal Detachment	F	M	B	S	GP
Strabismus	F	M	B	S	GP