LAST NAME_____FIRST NAME_____M. INTIAL_____DATE_____

VISUAL/HEALTH INFORMATION

Date of Last Eye Exam _____

Doctor's Name_____

Do You Wear Glasses? ❑ YES ❑ NO

❑ All the time ❑ Occasionally ❑ TV

❑ Reading ❑ Driving ❑ Computer

❑ Music ❑ Hunting/Shooting ❑ Sports

Do You Have a Copy of Your Prescription?

❑ Yes ❑ No (if yes please show receptionist)

Do you have:	Yourself	Family Members	If Yes Who
Glaucoma	❑ YES ❑ NO	❑ YES ❑ NO	_____
Cataracts	❑ YES ❑ NO	❑ YES ❑ NO	_____
Macular Degeneration	❑ YES ❑ NO	❑ YES ❑ NO	_____
High Blood Pressure	❑ YES ❑ NO	❑ YES ❑ NO	_____
Diabetes	❑ YES ❑ NO	❑ YES ❑ NO	_____
Eye Surgery	❑ YES ❑ NO	If Yes What Kind_____	When_____

Do You Wear Contacts ❑ Yes ❑ No Type_____ Hours/Day_____ Are you having any problems with your contacts? ❑ Yes ❑ No

MEDICATIONS: (If you have a list receptionist will take a copyof it)

Name of Medicine incl. Eye Drops & Vitamins	Dosage	Frequency	How you take it (Example by mouth, drops, cream)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List Any ALLERGIES to medications or other Substances/ Reaction and Onset Date

_____ _____ _____

1) Allergic/Immunologic None ❑
- ❑ Drug allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Lupus
- ❑ Other_____

2) Eyes None. ❑
- ❑ Glaucoma
- ❑ Cataracts
- ❑ Macular Degeneration
- ❑ Surgery
- ❑ Inflammatory disorders
- ❑ Blurred vision
- ❑ Double vision
- ❑ Other_____

3) Musculoskeletal None ❑
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Ankylosing spondylitis
- ❑ Other_____

4) Cardiovascular None ❑
- ❑ Heart Disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Vascular Disease
- ❑ Other_____

5) Gastrointestinal None ❑
- ❑ Crohn's
- ❑ Colitis
- ❑ Ulcer
- ❑ Digestive
- ❑ Other_____

6) Neurological None ❑
- ❑ Multiple sclerosis
- ❑ Epilepsy
- ❑ Alzheimers
- ❑ Parkinsons
- ❑ Cerebrovascular
- ❑ Other_____

7) Constitutional None ❑
- ❑ Developmental disability
- ❑ Weight loss
- ❑ Fever
- ❑ Fatigue
- ❑ Trauma
- ❑ Other _____

8) Genitourinary None ❑
- ❑ STD, Viral Herpetic, Chlamydia
- ❑ Other_____

9) Psychiatric None ❑
- ❑ Depression
- ❑ Panic disorder
- ❑ Schizophrenia
- ❑ Other_____

10) Ear, Nose, Mouth & Throat None ❑
- ❑ Upper Resp. Tract Infection
- ❑ Ear ache
- ❑ Runny nose
- ❑ Sore throat
- ❑ Ringing/Tinitis
- ❑ Other_____

11) Hematologic/Lymphatic None ❑
- ❑ Anemia
- ❑ Large volume blood loss
- ❑ Leukemia
- ❑ Other_____

13) Respiratory
- ❑ Smoker ❑ Non Smoker
- ❑ Former Smoker
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Other_____

14) Endocrine None ❑
- ❑ Non-insulin dependent diabetes
- ❑ Insulin-dependent diabetes
- ❑ Thyroid dysfunction
- ❑ Hormonal dysfunction
- ❑ Other_____

15) Integumentary None ❑
- ❑ Eczema
- ❑ Rosacea
- ❑ Psoriasis
- ❑ Other_____

❑ Height_____ft_____in

❑ Weight_____lbs