

Name: _____ Date: _____

E-Mail Address _____

Would you like to have the Optomap today? No Yes I would like to speak to the doctor

When was your last physical exam (including blood work)? _____ HbA1c _____

Who is your primary Care Physician (Name, address, and phone number if possible)

What is your current: Height _____ Weight _____

New Patients: When was your last comprehensive eye exam? _____

Race

- Asian Native American
 Black Caucasian
 Other Refuse to specify

ETHNICITY

- Hispanic
 Non-Hispanic
 Other _____

What is your preferred language?

- English Spanish French Italian Russian Portuguese

Occupation: _____ How many years? _____ Employer: _____

Social History

- Do you drink alcohol? No Occ 1 Per Day 2-3 Per Day 4+ Per Day
Do you smoke? No Yes ½ Pack/Day 1 Pack/Day 1+ Pack/Day
Past smoker No Yes When did you quit smoking? _____
Do you chew tobacco? No Yes
Do you use nutritional supplements? No Yes
Do you engage in regular exercise? No Yes
Hobbies / Interest? _____
-

Visual History

- Computer used? No Yes How many hours/day? _____ Distance from computer? _____
Do you drive? No Yes Daily mileage? _____
Do you have glare problems? No Yes
Do you have visual difficulty when driving? No Yes
Do you have problems with night vision? No Yes

Glasses

- Do you currently wear glasses? No Yes Since: _____
Type of glasses: Full Time Part Time Distance Close
Glasses Owned: Single Vision Bifocals Trifocals Backup Safety
 Sports Progressive
Have you had trouble in the past with glasses? No Yes _____
Do you wear sunglasses? No Yes
Are your sunglasses your current prescription? No Yes

Contact Lens History

- Have you ever tried to wear contact lenses? No Yes Reason for stopping? _____
If you are not a contact lens wearer, are you interested in trying contacts at this time? No Yes
Do you currently wear contact lenses? No Yes Since: _____
Type and brand of contacts: _____
How many hours per day? _____ How many days per week? _____ How long today? _____
Cleaner: _____ Disinfectant: _____ Enzyme: _____

Medication

List any drug allergies: _____

List allergic reaction: _____

List current medications/dosage:

Past surgeries/dates/surgeon:

Eye Disease

- Amblyopia (lazy eye)
- Blepharitis
- Blindness
- Cataract
- Color Blindness
- Diabetic Retinopathy
- Dry Eye Syndrome
- Eye Injuries
- Glaucoma
- Glaucoma Suspect
- High Risk Medication
- Macular Degeneration
- PVD
- Retinal Detachment
- Strabismus (eye turn)
- Other

Current Eye Symptoms

- Glare Sensitivity
- Headaches
- Light Sensitivity
- Tired Eyes
- Burning
- Dryness
- Epiphora
- Eyelid Swelling
- Eye Pain/Soreness
- Foreign Body Sensation
- Infection of Eye Lid
- Itching
- Mucus
- Ptosis (drooping eyelid)
- Redness
- Sandy or Gritty Feeling
- Other

Visual Symptoms

- Blurred Vision Distance
- Blurred Vision Near
- Distorted Vision
- Double Vision
- Flashes of Light
- Floaters or Spots
- Fluctuating Vision
- Loss of Central Vision
- Loss of Side Vision
- Loss of Vision
- Other

Review of Systems

- Constitutional Symptoms (fever, weight loss, etc.)
- Ears, Nose, Throat
- Cardiovascular (heart, hypertension)
- Respiratory (asthma, emphysema, etc.)
- Gastrointestinal
- Genital, Kidney, Bladder
- Muscles, Bones, Joints (arthritis, etc.)
- Skin (acne, skin cancer, etc.)
- Neurological (multiple sclerosis, etc.)
- Psychiatric (anxiety, depression, etc.)
- Endocrine (diabetic, hypothyroid, etc.)
- Blood/Lymph (anemic, cholesterol, etc.)
- Allergic/Immunologic (seasonal allergies, lupus, etc.)
- Pregnant
- Nursing

Family History (indicate father, mother, *paternal/maternal* grandmother, *paternal/maternal* grandfather, etc.)

- | | | |
|--|---|---|
| <input type="radio"/> Amblyopia (lazy eye) _____ | <input type="radio"/> Retinal Detachment _____ | <input type="radio"/> Lupus _____ |
| <input type="radio"/> Blindness _____ | <input type="radio"/> Strabismus (eye turn) _____ | <input type="radio"/> Stroke _____ |
| <input type="radio"/> Cataract _____ | <input type="radio"/> Arthritis _____ | <input type="radio"/> Thyroid Disease _____ |
| <input type="radio"/> Color Blindness _____ | <input type="radio"/> Cancer _____ | <input type="radio"/> Other Disease _____ |
| <input type="radio"/> Eye Tumor _____ | <input type="radio"/> Diabetes _____ | <input type="radio"/> Other _____ |
| <input type="radio"/> Glaucoma _____ | <input type="radio"/> Heart Disease _____ | |
| <input type="radio"/> Glaucoma Suspect _____ | <input type="radio"/> High Blood Pressure _____ | |
| <input type="radio"/> Macular Degeneration _____ | <input type="radio"/> Kidney Disease _____ | |