Please Fill Out Completely

Personal & Insurance Information: Today's Date:_____/_____/_____

Patient's Name (Mr. Mrs., Ms, Dr):_____ Date of Birth:_____/_____/_____

Address:_____ Cell: (_____) _____ ☐ Preferred

City:_____ State_____ Zip:_____ (H) or (W) (_____) _____ ☐ Preferred

Email Address:_____ Employer: _____

Medical Insurance:_____ ID#:_____ Vision Ins.:_____ ID#:_____

Primary Insured's Name & Social Security#: _____ & _____-_____-_____ Patient's Social Security#:_____-_____-_____

Medical History:

Do you have DIABETES? ☐YES ☐NO How many years?_____ Using Medication? ☐YES ☐NO
Do you have HYPERTENSION? ☐YES ☐NO How many years?_____ Using Medication? ☐YES ☐NO
Do you have Cholesterol Problems? ☐YES ☐NO How many years?_____ Using Medication? ☐YES ☐NO
Are you ALLERGIC to Medications? ☐YES ☐NO Which:_____

Medications: (Please list any and all Medications including Over the Counter, Homeopathic, Birth Control or Remedies):_____

_____

List and date all Major Injuries, Surgeries, and Hospitalizations you have had:

_____

Review Of Systems (ROS): Do you have Current or Past problems with:

Constitutional:	Fever, Weight Loss, Appetite	☐YES	☐NO
Integumentary:	Skin conditions/disorders	☐YES	☐NO
Neurological:	Headaches, Migraine, Seizures	☐YES	☐NO
Endocrine:	Thyroid, Diabetes	☐YES	☐NO
Ears, Nose Throat:	Allergies, Sinus, Cough, Dry Throat/Mouth	☐YES	☐NO
Respiratory:	Asthma, Emphysema, Bronchitis	☐YES	☐NO
Vascular:	Hypertension, Stroke, Heart Pain	☐YES	☐NO
Gastrointestinal:	Diarrhea, Constipation	☐YES	☐NO
Genitourinary:	Genitals, Kidneys, Bladder	☐YES	☐NO
Bones/ Joints:	Rheumatoid Arthritis, Muscle Pain	☐YES	☐NO
Lymphatic/Hematologic:	Anemia, Bleeding	☐YES	☐NO
Allergic Immunologic:	Allergies, Immune	☐YES	☐NO
Psychiatric:	Depression, Anxiety	☐YES	☐NO

Ocular ROS:		**Indicate which eye(s)**	
Sudden Vision Loss	☐YES ☐NO	R	L
Blurred Vision	☐YES ☐NO	R	L
Loss of Side Vision	☐YES ☐NO	R	L
Double Vision	☐YES ☐NO	R	L
Floaters	☐YES ☐NO	R	L
Flashes of Light	☐YES ☐NO	R	L
Mucus Discharge	☐YES ☐NO	R	L
Redness	☐YES ☐NO	R	L
Gritty Feeling/Dryness	☐YES ☐NO	R	L
Itching/ Burning	☐YES ☐NO	R	L
Tearing/Watery	☐YES ☐NO	R	L
Glare/Light Sensitivity	☐YES ☐NO	R	L
Eye Pain/ Discomfort	☐YES ☐NO	R	L
Haloes at Night	☐YES ☐NO	R	L

Are you sensitive to (circle all that apply) Heaters, Blowers, Air Conditioning, Cigarettes, Smog, Dust, Pollen, Contacts, Contact Lens Solutions, Animals

Family History:

			Relationship to you (parents, grandparents, siblings):
Blindness	☐YES	☐NO	_____
Cataracts	☐YES	☐NO	_____
Glaucoma	☐YES	☐NO	_____
Macular Degeneration	☐YES	☐NO	_____
Retinal Disease	☐YES	☐NO	_____
Arthritis	☐YES	☐NO	_____
Cancer	☐YES	☐NO	_____
Diabetes	☐YES	☐NO	_____
High Blood Pressure	☐YES	☐NO	_____
Heart Disease	☐YES	☐NO	_____
Kidney Disease	☐YES	☐NO	_____
Thyroid Disease	☐YES	☐NO	_____

Any Other? Explain: _____

PCP Name: _____

PCP Phone #: _____

Last Medical/Physical Exam:_____

Are you under any Medical Treatment? ☐YES ☐NO
For?_____

Last EYE exam:_____

Females:
Are you Pregnant/Nursing? ☐YES ☐NO

Social: (this information is strictly confidential, you may discuss this part with the doctor)☐Check here to discuss with Doctor

Do you drive? ☐YES ☐NO Do you have visual difficulty driving? ☐YES ☐NO Explain_____
Use of tobacco products? ☐YES ☐NO
Use of alcohol products? ☐YES ☐NO
Use of illicit drugs? ☐YES ☐NO
Have you been exposed to any Infectious Disease (HIV, STD's, Hepatitis, TB) ☐YES ☐NO Explain_____

Reviewed by (Doctor Initials): _____ ☐Glyn Pearson O.D. ☐Mike Phillips O.D.