REASON FOR TODAY'S EXAM _____

Name: _____ Birthdate: _____

Address: _____

City _____ State _____ Zipcode _____

_____ Male _____ Female _____

Home phone # _____ Work # _____ Cell # _____

Primary Care Physician _____

Employer _____ Occupation _____

Parent/Guardian if a minor _____

Are you interested in learning if contact lenses are an option for you? Yes No

Are you interested in learning if laser vision correction is an option for you? Yes No

Family History

Which members of your family have the following

Glaucoma? _____

Cataracts? _____

Macular Degen? _____

Hypertension? _____

Diabetes? _____

Heart disease? _____

Are you a s smoker? Please circle which applies:

Current every day smoker Current some day smoker

Former smoker Never smoker

What is your ethnicity _____ Non Hispanic _____ Hispanic/Latino

What is your race African American American Indian Asian

Pacific Islander White Other

What is your preferred spoken language Chinese English Korean

Spanish Tagalog Vietnamese

Other

What is your preferred written language Chinese English Korean

Spanish Tagalog Vietnamese

Other

NEW PATIENTS ONLY:

Who referred you to our office? _____

When was the date of your last eye exam? _____

CIRCLE ALL THAT APPLY

Constitution
- None
- Fever
- Malaise
- Weight loss
- Weight gain

Integumentary(skin)
- None
- Skin lesions
- Rash
- Psoriasis
- Edema
- Eczema
- Cancer

Eyes
- No problem
- Shingles
- Stye
- Double vision
- Amblyopia (Lazy eye)
- Blurred vision
- Blepharitis
- Blepharochalasis
- Cataracts
- Diabetic retinopathy
- Distorted vision
- Dry eyes
- Epiphora (tearing)
- Tired
- Flashes
- Floaters
- Glaucoma
- Legally blind
- Loss of vision
- Macular degeneration

Gastrointestinal
- None
- Acid reflux
- Gerd
- Diarrhea
- Hiatal hernia

Vascular/Cardiovascular
- None
- Elevated cholesterol
- High blood pressure
- Congestive heart disease
- Vascular disease

Genitourinary
- None
- Kidney failure
- Bladder
- STD
- Prostate
- Pregnant
- Nursing

Musculoskeletal
- None
- Ankylosing spondylitis
- Arthritis
- Joint pain
- JRA
- Muscle pain
- Myasthenia gravis
- Osteoarthritis
- Osteoporosis
- Rheumatoid arthritis

Neurological
- None
- Alzheimers
- Epilepsy
- Migraines
- Multiple sclerosis
- Myasthenia gravis
- Seizures

Endocrine
- None
- Diabetes
- Kidney disease
- Kidney stones
- On dyalysis
- Thryroid disease
- Pituitary

Lymphatic/Hematologic
- None
- Anemia
- Bleeding problems
- Lymphadenopathy

Immunologic
- None
- HIV
- Current chemotherapy

Psychiatric
- None
- Depression
- ADD
- ADHD
- Anxiety

Ears, Nose, Mouth, Throat
- None
- Allergies/hayfever
- Hearing aids
- Sinus
- Runny nose
- Chronic cough

Respiratory
- None
- Asthma
- Emphysema

List all meds you are taking _____

_____

List all allergies _____