Family Eye Clinic & Contact Lens Center

Date: ____/____/____ Reviewed: ____/____/____ Reviewed: ____/____/____

Last Name: _____ First Name: _____ Birthdate:____/____/_____

Address: _____ City: _____ State:____ Zip: _____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

E-mail:_____ M or F SSN:____/_____/_____ Spouse/Parent _____
(circle one)

Employer: _____ Occupation or Grade in School: _____

CASE HISTORY/REASON FOR VISIT:

Date of Last Medical Exam: ____/____/____ Primary Physician/Clinic: _____

Date of Last Eye Exam: _____/_____/_____ Eye Doctor/Clinic (if not here):_____

Do you wear glasses? **Yes No** Prescription Sun Wear? **Yes No** How old are your present glasses? _____

Do you wear Contact Lenses? **Yes No** Type: **Gas Permeable Soft** Solutions Used:_____

Wearing Schedule: **Daily Overnight** Replacement Schedule: **Daily 2-Week Monthly Yearly**

Are they comfortable? **Yes No** Are you interested in Colored Contact Lenses?: **Yes No**

Have you ever had any eye injuries? **Yes No** Have you ever had eye surgery? **Yes No**

If Yes, which eye? **Right Left Both** When?_____

Have you been diagnosed or are you being treated for any eye condition? **Yes No** _____

Are you experiencing any change in vision? **Yes No** If Yes with **Contacts Glasses No Correction**

Problems occurring at **Near Far Computer**

Please check any problems you are currently experiencing:

Vision Loss	[ ]	Pain	[ ]	Computer Use	[ ]
Eyestrain	[ ]	Light Sensitivity	[ ]	Golf	[ ]
Tearing	[ ]	Redness	[ ]	Needlework/Sewing	[ ]
Burning	[ ]	Discharge	[ ]	Music	[ ]
Itching	[ ]	Foreign Object	[ ]	Skiing	[ ]
Floaters/Spots	[ ]	Trauma/Injury	[ ]	Tennis	[ ]
Headaches	[ ]	Sandy/Gritty	[ ]	Racquetball	[ ]
				Baseball/Softball	[ ]
				Water Sports/Fishing	[ ]
				Power Tool Use	[ ]

Please check any activities you participate in:

Personal Medical History (Review of Systems) Please check if any of the following applies to you and List any medications for each condition that you check. If you have none of these conditions check **None.**

Cardiovascular: ___None ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease/High Cholesterol ___Other	**Endocrine:** ___None ___Noninsulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid (Hypo/Hyper) ___Hormone Therapy ___Other	**Respiratory:** ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other
Constitutional: ___None ___Cancer ___Large Weight Gain/Loss ___Developmental Disability ___Other	**Genitourinary:** ___None ___Kidney Disease ___Urinary Tract Infection ___STD Herpes/Chlamydia ___Other	**Psychiatric:** ___None ___ADHD ___Depression ___Schizophrenia ___Other
Neurological: ___None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other	**Musculoskeletal:** ___None ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other	**Immunologic:** ___None ___AIDS or HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other
Hematological: ___None ___Anemia ___Leukemia ___Other	**Gastrointestinal:** ___None ___Crohn's ___Acid Reflux ___Other	**Ear/Nose/Throat:** ___None ___Hearing Loss ___Upper Respiratory Infection ___Other
Dermatologic: ___None ___Eczema ___Rosacea ___Psoriasis ___Other	**Allergies : (Please List)** ___None Drugs: Environmental:	**Alcohol Use: Y N** Amount: **Tobacco Use: Y N** Amount:

Please list any medications (prescription/herbal/over the counter) that you are taking for conditions above:

_____

_____

Family Medical History:

If "YES" please explain who in your family (grandparents, parents, siblings)

High Blood Pressure	**Y**	**N**	_____
Heart Disease	**Y**	**N**	_____
Thyroid Disease	**Y**	**N**	_____
Diabetes	**Y**	**N**	_____
Arthritis/Lupus	**Y**	**N**	_____
Cancer	**Y**	**N**	_____

Family Eye History:

Blindness	**Y**	**N**	_____
Cataracts	**Y**	**N**	_____
Glaucoma	**Y**	**N**	_____
Crossed Eyes	**Y**	**N**	_____
Macular Degeneration	**Y**	**N**	_____
Retinal Detachment/Disease	**Y**	**N**	_____

Reviewed By: _____ **Date:**_____/_____/_____