LAKESHORE VISION CENTER

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____ M _____

DOB: ____/____/____ M or F SSN: _____ / _____ / _____ Marital Status: Married / Single / Divorced /Widowed

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

Home Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

CASE HISTORY / REASON FOR VISIT:

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

Date of Last Eye Exam:_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes/No/All the time/Sometimes/Work only/Reading only/Driving only

How old are your present glasses? _____ Do you wear prescription sun wear? Yes/No

Do you wear contacts? Yes No Type:_____ Solution Used: _____

Wearing schedule: Daily Overnight Replacement schedule: Daily 2 Week Monthly Yearly

Are you interested in trying contacts? Yes No

Have you ever had eye injuries? Yes No Which Eye?_____ Type of Injury: _____

Have you ever had eye surgeries? Yes No Why?_____

Have you used eye drops? Yes No Why?_____

Are you currently pregnant or nursing? Yes No

Reason for today's visit? _____

_____

Have you ever been diagnosed with?

Cataracts: Yes/No

Glaucoma: Yes/No

Macular Degeneration: Yes/No

Diabetes Yes/No When were you diagnosed? _____ Last A1C _____

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate severity (Low) (Moderate) (High)

Blurred Vision/Distance	L M H	Dry Eyes	L M H	See Halos	L M H
Blurred Vision/Near	L M H	Sandy/Gritty Feeling	L M H	Poor Night Vision	L M H
Double Vision	L M H	Red Eyes	L M H	Light Sensitive	L M H
Headaches	L M H	Watery Eyes	L M H	Droopy Lid	L M H
Eye Strain	L M H	Mucus Discharge	L M H		
Burning Eyes	L M H	Floaters or Spots	L M H		
Itchy Eyes	L M H	See Flashes	L M H		

Please turn over and complete other side

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.

Cardiovascular: ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** ___ Uveitis ___ Macular Degeneration ___ Detached Retina ___ Other:	**Psychiatric:** ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies** (please list) **__ None** Drug: Environmental:	**Alcohol Use: Y N** Amount: **Tobacco Use: Y N** Amount:

Please list physical reactions to above allergies: _____

_____

Please list any medications, supplements, and/or drugs that you are taking (including herbal) : See Attached List: _____

1	**For**	**6**	**For**
2	**For**	**7**	**For**
3	**For**	**8**	**For**
4	**For**	**9**	**For**
5	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children – living or deceased) been diagnosed with:

DISEASE / CONDITION		**WHO**	**DISEASE / CONDITION**		**WHO**
Retinal Detachment:	Yes/No		Blindness:	Yes/No	
High Blood Pressure:	Yes/No		Cataracts:	Yes/No	
Diabetes:	Yes/No		Glaucoma:	Yes/No	
Cancer:	Yes/No		Crossed Eyes:	Yes/No	
Heart Disease:	Yes/No		Macular Degen:	Yes/No	
Thyroid Disease:	Yes/No				