LAKESHORE VISION CENTER

General Information Date: _____/______/_______

Last Name__________________________________ First Name: ___________________________________ M _______

DOB: ____/____/____ M or F Last 4 of 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

Skip this section if last exam was at Lakeshore Vision Center

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

Skip this section if last exam was at Lakeshore Vision Center

Diabetes Yes/No When were you diagnosed? ____________________ Last A1C ___________

What are your visual symptoms? Please circle any that apply:

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

Blurred Vision/Distance	L M H	Dry Eyes	L M H
Blurred Vision/Near	L M H	Sandy/Gritty Feeling	L M H
Double Vision	L M H	Red Eyes	L M H
Headaches	L M H	Watery Eyes	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
See Halos	L M H		
Poor Night Vision	L M H		
Light Sensitive	L M H		
Droopy Lid	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:	**Endocrine:**	**Respiratory:**
___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	___ 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				