

General Information

Last Name _____ First Name _____ MI _____
 DOB ____/____/____ M / F Last 4 of SSN _____ Marital Status: Married / Single / Divorced / Widowed
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Employer/School _____ Occupation/Grade _____
 Email Address _____ Sports/Hobbies _____

Reason for Today's Visit

Please Check All Items You Would Like Evaluated

<p>Routine Exam</p> <p><input type="checkbox"/> Eye Health Check</p> <p><input type="checkbox"/> New Glasses</p> <p><input type="checkbox"/> Contact Lenses</p>	<p>Medical Exam</p> <p><input type="checkbox"/> Diabetic Exam</p> <p><input type="checkbox"/> Glaucoma, Macular Degeneration, Cataracts</p> <p><input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Eye Irritation (burning, itching, redness, watering, dry)</p> <p><input type="checkbox"/> Flashes and/or Floaters</p> <p><input type="checkbox"/> Droopy Eyelid</p> <p><input type="checkbox"/> Other (Please Specify) _____</p>
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Ocular History

Date of Last Medical Exam _____ Primary Physician/Clinic _____
 Have you ever been diagnosed with diabetes? Yes / No When were you diagnosed? _____ Last A1C Value _____
 Are you interested in trying contact lenses? Yes / No How old are your present glasses? _____
 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

*******Skip the following questions if your last exam was at Lakeshore Vision Center*******

Date of Last Eye Exam _____ Clinic/Eye Doctor's Name _____
 Do you wear glasses? All The Time / Driving / Reading / At Work
 Do you wear contacts? Yes / No Type _____ Solution Used _____
 Contact Wearing Schedule: Daily / Overnight Replacement Schedule: Daily / 2 Week / Monthly / Yearly
 Have you ever been diagnosed with the following? Cataracts Glaucoma Macular Degeneration

Personal Medical History (Review of Systems): Please check if any of the following applies to you.

Cardiovascular: ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	Endocrine: ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Other:	Respiratory: ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Ocular: ___ Uveitis ___ Macular Degeneration ___ Detached Retina ___ Other:	Constitutional: ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	Psychiatric: ___ ADHD ___ Depression ___ Anxiety ___ 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) <input type="checkbox"/> 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) OR attach a list:

List Attached

- | | |
|----------|-----------|
| 1. _____ | 6. _____ |
| 2. _____ | 7. _____ |
| 3. _____ | 8. _____ |
| 4. _____ | 9. _____ |
| 5. _____ | 10. _____ |

Family History: Has anyone in your family (grandparents, parents, siblings, children--living or deceased) been diagnosed with:

- | | |
|---------------------------------------|---------------------------------|
| Retinal Detachment: Y / N Who? _____ | Blindness: Y / N Who? _____ |
| High Blood Pressure: Y / N Who? _____ | Cataracts: Y / N Who? _____ |
| Diabetes: Y / N Who? _____ | Glaucoma: Y / N Who? _____ |
| Heart Disease: Y / N Who? _____ | Crossed Eyes: Y / N Who? _____ |
| Thyroid Disease: Y / N Who? _____ | Macular Degen: Y / N Who? _____ |