LAKESHORE VISION CENTER Date: ______ /______ / ______

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

Routine Exam

- ☐ Eye Health Check
- ☐ New Glasses
- ☐ Contact Lenses

Medical Exam

- ☐ Diabetic Exam
- ☐ Glaucoma, Macular Degeneration, Cataracts
- ☐ Double Vision
- ☐ Headaches
- ☐ Eye Irritation (burning, itching, redness, watering, dry)
- ☐ Flashes and/or Floaters
- ☐ Droopy Eyelid
- ☐ Other (Please Specify) _________________________

Patient 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) ☐ **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. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________
9. ____________________
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? ________