Eyes On Elburn

Date: ____/_____/_____

General Information

Last Name_____ First Name_____ M_____ DOB: ____/____/_____

Male* or *Female Marital Status: ***Married / Single / Divorced***

Address: _____City_____State_____Zip_____

Home Ph: (_____) _____Work Ph: (_____) _____Cell Ph: (_____) _____

Employer/School: _____Occupation/School Grade: _____

Email Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone: (___) _____

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***

Have you ever had eye injuries? ***Yes/No*** Which eye? _____

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

Have you used eye medication? ***Yes/No*** Why? _____

Are you currently pregnant or nursing? ***Yes/No*** ***N/A***

Have you ever been diagnosed with?

Cataracts: ***Yes/No*** When were you diagnosed? _____

Glaucoma: ***Yes/No*** When were you diagnosed? _____

Macular Degeneration: ***Yes/No*** When were you diagnosed? _____

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

[ ] Blurred Vision/Distance [ ] Dry Eyes [ ] Headaches [ ] Red Eyes [ ] Migraine Headaches [ ] Double Vision

[ ] Blurred Vision/Near [ ] Watery Eyes [ ] Loss of Vision [ ] Eye Strain [ ] Wandering Eye [ ] Crossed Eye [ ] Eye Infections

[ ] Mucous Discharge [ ] Light Sensitive [ ] Eye Pain/Soreness [ ] Floaters or Spots [ ] Sandy/Gritty Feeling [ ] Tired Eyes

[ ] See Flashes [ ] Poor Color Vision [ ] Burning Eyes [ ] See Halos [ ] Droopy Lid [ ] Itchy Eyes [ ] Poor Night Vision

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Date: ____/_____/_____

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, PLEASE CHECK NONE.

Cardiovascular: ___None ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	Endocrine: ___None ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other:	Respiratory: ___None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional: ___None ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:	Ocular: ___None ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	Psychiatric: ___None ___ADHA ___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 ___Colitis ___Other:	Ear/Nose/Throat: ___None ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic: ___None ___Eczema ___Rosacea ___Psoriasis ___Other:	Allergies: ___None Drug: Seasonal/Environmental:	**Alcohol Use: Y N** Amount: **Tobacco Use: Y N** Amount:

Please list physical reactions to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal):

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

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

Disease/Condition:		Relation:			Relation:
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 Degeneration	**Yes/No**	
Thyroid Disease	**Yes/No**		Lupus	**Yes/No**	

Reviewed by:

Dr. _____ Date: _____