21 NORTH EYECARE

Date:_____ Name: _____ Date of Birth: _____

Height: _____ Weight: _____ Occupation: _____

REASON FOR VISIT: What is the reason for today's visit? _____

_____

EYE CONDITIONS: Do you currently have any of the following eye conditions (select)?:

☐Cataract ☐Age-Related Macular ☐Degeneration ☐Glaucoma ☐Diabetic Retinopathy ☐Dry Eye

☐Eye Infection ☐Eye Allergies ☐Floaters or Flashes ☐Iritis ☐Retina Defects or Degenerations

EYE CONCERNS/ VISION CONCERNS: Are you having any of the following problems with your eyes (select)?:

☐redness ☐burning ☐itching ☐tearing ☐discharge ☐dryness

☐blurred vision ☐eyestrain ☐eye pain ☐light sensitivity ☐headaches ☐poor night vision /glare
☐double vision ☐total vision loss

VISION CORRECTION:

Do you wear glasses? ☐Yes ☐No

If yes, what do you wear them for?: ☐Distance vision ☐Near vision ☐Computer vision

If yes, what kind of glasses: ☐Single Vision ☐Bifocal ☐Progressive

Do you wear contact lenses? ☐Yes ☐No If yes, please answer the following questions:

Brand? _____

Power?: Right eye _____ Left eye _____

How old are your current lenses? _____

What is your average daily wearing time? _____ How many days per week do you wear contacts? _____

How often do you replace your lenses? ☐Daily ☐Weekly ☐Monthly ☐Quarterly ☐Annually ☐Other:

Do you ever sleep in your contact lenses? ☐Yes ☐No

What cleaning solution do you use? _____

Do you suffer from dry eye with contact lens wear? ☐Yes ☐No

Are you interested in multifocal contact lenses? ☐Yes ☐No

Are you interested in colored contact lenses? ☐Yes ☐No

REVIEW OF SYSTEMS

Do you currently have any of the following problems?: (please select all that apply)

Constitution: ☐fever ☐malaise ☐weight loss ☐weight gain

Ear, Nose, Throat: ☐sinus problems ☐hearing loss ☐chronic cough ☐dry mouth

Neurologic: ☐headaches ☐seizures ☐Multiple Sclerosis ☐Alzheimer's ☐Parkinson's

Psychiatric: ☐depression ☐anxiety ☐ADD ☐ADHD ☐schizophrenia

Cardiovascular: ☐high cholesterol ☐hypertension ☐atrial fibrillation ☐congestive heart disease ☐coronary artery disease

Respiratory: ☐asthma ☐bronchitis ☐emphysema ☐sleep apnea

Gastrointestinal: ☐acid reflux ☐GERD ☐diarrhea ☐hiatal hernia ☐IBS ☐Chron's

Genitourinary: ☐kidney disease ☐bladder problems STDs ☐BPH (enlarged prostate) ☐pregnancy

Musculoskeletal: ☐arthritis ☐ankylosing spondylitis ☐joint pain ☐rheumatoid arthritis ☐myasthenia gravis

Skin problems: ☐acne ☐psoriasis ☐eczema ☐rosacea

Endocrine: ☐diabetes ☐thyroid disease ☐pituitary dysfunction ☐adrenal dysfunction

If yes to diabetes, when were you diagnosed? _____

What was your last blood sugar? _____

What was your last hemoglobin A1c? _____

Lymphatic/Hematologic: ☐anemia ☐leukemia ☐lymphoma ☐sickle cell ☐bleeding problems ☐multiple myeloma

Allergy/Immunologic: ☐Allergies ☐Lupus ☐Sjogren's syndrome ☐Rheumatoid arthritis ☐Autoimmune disease

Other: _____

MEDICATIONS Please list all medications currently used, including over the counter and supplements. Indicate the medication name, purpose, dosage, and how long you have been taking the medication:

_____

_____

_____

_____

ALLERGIES Please list all allergies: _____

_____

PAST OCULAR HISTORY

Please list any eye problems you have been previously diagnosed with or treated for:

_____

_____

Please list any previous eye surgeries:

_____

_____

SOCIAL HISTORY (please select all that apply)

Tobacco Use: ☐Never ☐Former (quit ____ years ago) ☐Current (cigarettes/cigars/chewing, _____ per day)

Alcohol Use: ☐No consumption ☐Socially only ☐Daily ☐How much per week? _____

PAST MEDICAL HISTORY

List all previous medical conditions you have been treated for: _____

_____

_____

List all previous hospitalizations: _____

_____

List all previous surgeries: _____

_____

FAMILY OCULAR HISTORY List any eye conditions in your family and which indicate which family member(s):

Cataracts:_____

Macular degeneration:_____

Glaucoma:_____

Other:_____

FAMILY MEDICAL HISTORY List any medical problems in your family and indicate which family member(s):

Cancer: _____

Diabetes:_____

Hypertension:_____

Hyper or Hypothyroidism: _____

Other:_____