Visual Information

Please check all that you are currently experiencing:

Blurry far away	___	Dry Eyes	___
Blurry up-close	___	Sandy/gritty	___
Floaters or spots	___	Eyes burn	___
Eyes water easily	___	Pain in or around	___
Amblyopia (lazy eye)	___	Redness	___
Loss of vision	___	Fluctuating vision	___
Strabismus (crossed eyed)	___	Drooping Eyelid(s)	___
Infection of Eye or lid	___	Foreign body sensation	___
Retinal detachment	___	Eye Strain/tired eyes	___
Night vision problems	___	Light Sensitivity	___
Headaches	___	Haloes	___
Loss of Side Vision	___	Mucous Discharge	___
Itching	___		

Lifestyle Factors

Sports/Activities _____

Are you interested in contact lenses?	Yes ___ No ___
Do you have a pair of back-up glasses?	Yes ___ No ___
Do you have a pair of prescription sunglasses?	Yes ___ No ___
Does road glare/night vision bother you?	Yes ___ No ___
Do you have visual problems while on a computer (eye strain/tilt your head?)	Yes ___ No ___
How many hours per day do you work on the computer?	_____

I stopped wearing glasses ___

Do you drink alcohol? Yes___ No___ If so, how many drinks per day? _____

Do you smoke? Yes___ No___ If so, how often during the day? _____

Contact Lens Rating

I am interested in wearing contacts ___

Rate how your contacts feel immediately after you first put them in Poor1__2__3__4__5__Excellent

Indicate the time you put your contacts in _____

Rate how your contacts feel just before you take them out Poor1__2__3__4__5__Excellent

Indicate the time you take your contacts out _____

Do you use contact lens rewetting drops? Yes___ No___ If so, how often during the day? _____

I stopped wearing contacts ___

Health Information

Do you or anyone in your family have a history of (please check all that apply)

Diabetes	___self/family	Macular Degeneration	___self/family
Glaucoma	___self/family	High/Low Blood Pressure	___self/family
Cataract	___self/family	High/Low Cholesterol	___self/family

Please check off any current conditions you suffer from (please check all that apply)

___ Chronic fever, unexpected weight loss/gain, fatigue
___ Ear/nose/throat problems (eg. Hearing loss, sinus problems, sore throat)
___ Heart problems (eg. Chest pain, irregular heartbeat, swelling of feet, cold hands or feet)
___ Respiratory problems (eg. Shortness of breath, wheezing, coughing)
___ Gastrointestinal problems (Heartburn, abdominal pain, diarrhea, vomiting)
___ Genitourinary problems (eg. Painful urination, blood in urine, sex organ problems)
___ Musculoskeletal problems (eg. Muscle aches, joint pain, swollen joints)
___ Skin problems (eg. Rashes, excessive dryness, growths or lumps)
___ Neurological problems (eg. Numbness, weakness, headaches, "blackouts"
___ Psychiatric problems (eg. Depression, anxiety)
___ Endocrine problems (eg. Frequent urination, thirst, feeling hot or cold all the time)
___ Blood/Lymph problems (eg. Bruising, weakness, unusual paleness, swollen glands)
___ Immune problems (eg. Frequent infections, allergic reactions to foods, dust, pollens)

Please list any medications/dosage that you are currently taking:

_____

_____

_____

_____

Are you allergic to any medications? _____

NOTE: Your insurance plan is a contract between you and your insurance company. Our office cannot be responsible for determining your benefits. You must notify us if your insurance plan covers routine vision prior to any services. If you are not sure if your plan covers routine vision, payment is due at the time services are rendered. If your plan requires a referral, it is your responsibility to obtain one from your primary care doctor prior to your appointment. If your insurance denies the charges incurred, they are your responsibility.

Assignment of Benefits: I hereby consent to such treatment and patient care, which may be considered necessary or advisable as a patient of Adriana Palumbo, OD for services rendered. I understand that I am ultimately responsible for all charges on services rendered, whether or not paid by insurance.

_____

Signature or Patient or Guardian **Date**

In case of divorced or separated parents, our policy is that the parent bringing the child into our office is responsible for payment of all fees.