WELCOME TO GERARD EYE CO.

We appreciate you choosing us for your professional eye care.

Ms., Miss Mr., Mrs. (last)_____ (first)_____ (mi)____ Today's Date_____
Nickname_____ Single____ Married____ Widowed____Divorced_____
Home Address:_____ Date of Birth:_____/_____/_____
City:_____ ST:_____ Zip: _____ Home Phone: (_____)_____
Cell Phone: (_____)_____Work Phone: (_____)_____**Email:** _____
Preferred Phone Number: Cell Home Work Race:_____ Preferred Language: _____
Have we taken care of your family members:❑ Yes Whom?_____
May we thank someone for referring you? ❑ Yes Whom? _____
Medical Insurance:_____ Vision Insurance:_____
Policyholders Name:_____Policyholder's Employer: _____

LIFESTYLE QUESTIONAIRE **This will allow us to make recommendations for your specific eye care needs!**

What is the Reason(s) for your Visit Today? _____

_____When was your last eye exam? _____

Are you having vision problems without glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No

Glasses Do you wear glasses? ❑ Yes ❑ No If no, skip to the contact lenses section.
Are you having problems with your glasses? ❑Yes, distance ❑Yes, computer ❑Yes, near ❑ No
Are you interested in getting new glasses? ❑ Yes ❑ If my prescription changes ❑ No
Do your glasses have an anti-glare lenses? ❑ Yes ❑ No Do you have prescription sunglasses? ❑ Yes ❑ No

Contact Lenses Do you wear contact lenses? ❑ Yes ❑ No If no, do you want to try them today? ❑ Yes ❑ No
Are you interested in colored contacts? ❑Yes **Refractive Surgery** Are you interested in laser surgery? ❑Yes

Activities: Employer:_____Occupation: _____
Is it difficult to see when driving during the day? ❑ Yes ❑ No At night? ❑ Yes ❑ No
How many hours per day do you use the computer?_____
Do you spend time outdoors? ❑ Yes ❑ No How many hours per week? _____
What hobbies do you enjoy? _____
Do these activities strain your eyes? ❑ Yes ❑ No_____

(Please do not write below this line – For Office Use only) ***Proceed to back page***

Notes _____ **Insurance**_____
_____
_____
Glasses _____ **Contacts**_____
_____ _____
_____ _____
DIL ❑ PA ❑ Trop/ Phen❑ Caine ❑ Cyclate ❑ Decline Time_____ **OPTOS** ❑ Yes ❑ No ❑ ? **OCT** ❑ Yes ❑ No ❑ ?
Notes _____
_____

Recommend: A/R, Trans, _____Prog, SV_____, Comp/Read, Sport, Safety, Sun, Polz, BF TF
RTC: 1 year preappoint _____ _____@DISP

Social History *Please check the box if you prefer to discuss the following information with the doctor only.* ❑

Do you use tobacco products? ❑ Yes, every day ❑ Yes, some day ❑ No, never ❑ No, former smoker
Do you drink alcohol? ❑ Yes ❑ No If yes, type / amount / how long: _____
Do you use illegal drugs? ❑ Yes ❑ No If yes, type / amount / how long: _____

Ocular History *Do you have any eye problems?* ❑Cataracts ❑Macular Degeneration ❑Glaucoma ❑Diabetic ❑Dry Eye ❑Eye Infections ❑Allergies ❑Floaters ❑Flashes ❑Iritis /Uveitis ❑Retinal Detachment ❑Redness ❑Burning ❑Itching ❑Watery Eyes ❑Mucous Discharge ❑Eyestrain/Tired Eyes ❑Blurred Vision ❑Eye Pain ❑Light Sensitivity ❑Headaches ❑Poor Night Vision ❑Glare ❑Double Vision ❑Vision Loss ❑Eye Surgery ❑Lazy eye ❑Eye turn /Patching ❑Keratoconus ❑Eye Injury ❑Nystagmus ❑Droopy eyelid ❑Other_____

Medical History: Name of Medical Doctor:_____ Last Medical Exam:_____

Medications: ❑ No Medications ❑ Provided List_____

_____

Do you have any allergies? ❑ Yes ❑ No If yes, please list._____

_____

List all major injuries, surgeries and/or hospitalizations:_____

_____

Are you pregnant? ❑ Yes ❑ No ❑ Maybe Are you nursing? ❑ Yes ❑ No

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Review of Systems - **Please circle all that apply or fill-in the blank for those not listed.**

CONSTITUTIONAL: Developmental disabilities / Fatigue / Cancer, Type_____/ _____
EARS, NOSE, THROAT: Hearing loss / Sinusitis / Dry mouth / Laryngitis / _____
NEUROLOGICAL: Multiple sclerosis / Epilepsy / Cerebral Palsy / Tumor / Migraine / _____
PSYCHIATRIC: Depression / ADHD / Anxiety / Bipolar / _____
CARDIOVASCULAR: High blood pressure / Stroke / Heart disease_____
RESPIRATORY: Asthma / Bronchitis / Emphysema / Chronic obstruction / Sleep Apnea /_____
GASTROINTESTINAL: Crohn's / Colitis / Ulcer / Acid reflux / Celiac disease / _____
GENITOURINARY: Kidney disease / Prostate disease / Herpes / Chlamydia / _____
MUSCULOSKELETAL: Arthritis / Fibromyalgia / Ankylosing Spondylitis /Gout / _____ _____
INTEGUMENTARY: Eczema / Rosacea / Psoriasis / Cold Sores / Shingles / _____
ENDOCRINE: Type 2 Diabetes / Type 1 Diabetes / Hypothyroid / Hyperthyroid – Grave's Disease / _____
HEMOTOLOGIC / LYMPHATIC: Anemia / Blood Loss / Ulcer / High Cholesterol / _____
ALLERGIC / IMMUNOLOGIC: Rheumatoid Arthritis / Lupus / Sjogren's / HIV / Gonorrhea / Hepatitis / Syphilis / ____

Family History **List the family member(s) that has/had the following:** *(Ex. Mother, Grandparent, etc)*

Heart Disease _____ **Macular Degeneration** _____
High Blood Pressure_____ **Lazy Eye / Amblyopia**_____
Diabetes _____ **Eye Turn / Strabismus** _____
Cancer _____ **Nystagmus** _____
Thyroid Disease_____ **Retinal Detachment / Disease**_____
Cataract _____ **Arthritis** _____
Glaucoma_____ **Lupus** _____