General Information Date_____/_____/_____

Last Name_____ First Name_____ MI_____ DOB:____/____/____

Address:_____City:_____ State:____ Zip:_____

Home Phone:( )_____ Work Phone:( )_____ SS#:_____/_____/_____

Cell Phone:( )_____ Email Address:_____

Emergency Contact: Name:_____ Relation:_____ Phone#:( )_____

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Employer/School:_____ Occupation/School Grade:_____

Sports/Hobbies:_____ Number of Children?:_____ Ages:_____

I acknowledge that I am the financially responsible party for all procedures received at Elk River Eye Clinic

_____

(Patients Name) (Date)

CASE HISTORY / REASON FOR VISIT:

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type:_____ Replace Schedule:_____

Have you ever had eye injuries? Yes No Which Eye?_____

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

Have you taken eye medication? Yes No Why?_____

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?_____

PLEASE CIRCLE AND EXPLAIN ANY OF THE FOLLOWING FOR PAST OR PRESENT CONDITIONS THAT APPLY

Blurred Vision - Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision - Near	Itchy Eyes	See Flashes	Migrane Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

Are you currently pregnant or nursing? Yes No

Notes:

*** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE***

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	**Endocrine:** ___ None	**Respiratory:** __ None
___ Hypertension	___ Non-Insulin Dependent Diabetes	___ Asthma
___ Stroke	___ Insulin Dependent Diabetes	___ Bronchitis
___ Heart Disease	___ Thyroid Problem	___ Emphysema
___ Vascular Disease	___ Hormonal Dysfunction	___ COPD
___ Other:	___ Other:	___ Other:
___ Medications_____	___ Medications:_____	Medications:_____
Constitutional: __ None	**Genitourinary:** __ None	**Psychiatric:** __ None
___ Cancer	___ Kidney Disease	___ ADHD
___ Trauma/Large Volume Blood Loss	___ Urinary Tract Infection	___ Depression
___ Developmental Disability	___ STD - Herpetic/Chlamydia	___ Schizophrenia
___ Other:	___ Other:	___ Other:
___ Medications:_____	___ Medications:_____	___ Medications:_____
Neurological: __ None	**Musculoskeletal:** __ None	**Immunologic:** __ None
___ Multiple Sclerosis	___ Osteoarthritis	___ AIDS or HIV
___ Epilepsy	___ Fibromyalgia	___ Rheumatoid Arthritis
___ Cerebal Palsy	___ Muscular Dystrophy	___ Lupus
___ Tumor	___ Ankylosing Spondylitis	___ Neurofibromatosis
___ Other:	___ Other:	___ Other:
___ Medications:_____	___ Medications_____	___ Medications:_____
Hematological: __ None	**Gastrointestinal:** __ None	**Ear/Nose/Throat:** __ None
___ Anemia	___ Crohn's	___ Hearing Loss
___ Leukemia	___ Colitis	___ Upper Respiratory Infection
___ Other:	___ Other:	___ Other:
___ Medications:_____	___ Medications_____	___ Medications:_____
Dermatologic: __ None	**Allergies** (please list) __ None	
___ Eczema	Drug:	**Alcohol Use:** Y N
___ Rosacea		Amount:
___ Psoriasis		
___ Other:	Environmental:	**Tobacco Use:** Y N
___ Medications_____		Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

FAMILY HISTORY:

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

DISEASE / CONDITION

Blindness:	**Y**	**N**	Who?_____
Cataracts:	**Y**	**N**	Who?_____
Glaucoma:	**Y**	**N**	Who?_____
Crossed Eyes:	**Y**	**N**	Who?_____
Macular Degeneration:	**Y**	**N**	Who?_____
Retinal Detachment:	**Y**	**N**	Who?_____
High Blood Pressure:	**Y**	**N**	Who?_____
Diabetes:	**Y**	**N**	Who?_____
Cancer:	**Y**	**N**	Who?_____
Heart Disease:	**Y**	**N**	Who?_____
Thyroid Disease:	**Y**	**N**	Who?_____

Reviewed by:

Dr_____ Date_____ Dr_____ Date_____