EyeCare Associates, P.C.

Name:_____ Today's Date:_____/____/_____

Address:_____

City:_____ State:_____ Zip:_____ Referred by: _____

Patient's DOB: ____/____/____ Sex: _____ Medical Doctor: _____

Email Address: _____ Dr.'s Phone: _____

Cell Phone:_____ Last Medical Exam: _____/_____/_____

Home/Work Phone:_____ Last Eye Exam: _____/_____/_____

Emergency Contact/Phone:_____

Race:_____ Ethnicity: _____

Are you presently experiencing any of the following?

- ☐ Loss of Vision
- ☐ Blurred Vision (dist?/near?)
- ☐ Distorted Vision/Halos
- ☐ Loss of Side Vision
- ☐ Double Vision
- ☐ Eye turn in, out, up, down
- ☐ Dryness
- ☐ Mucous Discharge
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Excess Tearing/Watering
- ☐ Glare/Light Sensitivity
- ☐ Eye Pain or Soreness
- ☐ Chronic Infection of Eye/Lid
- ☐ Styes or Chalazion
- ☐ Flashes/Floaters in Vision
- ☐ Tired Eyes
- ☐ Difficulty with depth perception
- ☐ Difficulty with driving
- ☐ Difficulty with sports performance
- ☐ Visual discomfort on computer
- ☐ Slow reading
- ☐ Poor reading comprehension
- ☐ Lose place while reading
- ☐ Short attention span
- ☐ Clumsiness
- ☐ Backaches or neck aches
- ☐ Posture problems
- ☐ Other

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

- ☐ **Constitutional**
- ☐ Fever, Weight Loss/Gain
- ☐ **Integumentary** (Skin)
- ☐ **Neurological**
- ☐ Headaches
- ☐ Migraines
- ☐ Seizures
- ☐ Concussion
- ☐ **Ears, Nose, Mouth, Throat**
- ☐ Allergies/Hay Fever
- ☐ Sinus Congestion
- ☐ Runny Nose
- ☐ Post-Nasal Drip
- ☐ Chronic Cough
- ☐ Dry Throat/Mouth
- ☐ **Respiratory**
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ **Endocrine**
- ☐ Thyroid/Other Glands
- ☐ **Vascular/Cardiovascular**
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ **Gastrointestinal**
- ☐ Diarrhea
- ☐ Constipation
- ☐ **Genitourinary**
- ☐ **Genitals/Kidney/Bladder**
- ☐ **Bones/Joints/Muscles**
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ **Lymphatic/Hematologic**
- ☐ Anemia
- ☐ Bleeding Problems
- ☐ **Allergic/Immunologic**
- ☐ **Psychiatric**
- ☐ Attention Deficit Disorder
- ☐ Autism Spectrum Disorder

Visual History

Have you ever had vision therapy? No Yes If yes, the year and duration?_____

Have you ever had eye surgery? No Yes If yes, indicate the year and details _____

Do you wear glasses? No Yes Age of current lenses: _____

Do you wear contact lenses? No Yes Age of current lenses: _____ Type of lenses: _____

Solutions: _____ Comfort: _____ How often replaced: _____ Sleep in them? _____

List any of the following you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infection or eye injury, other:_____

Medical History/Family History

Pregnant and/or nursing? No Yes

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

Please note any personal/family history (parents, grandparents, siblings, children; living or deceased) for the following:

Disease/Condition	Self	Family	Relationship to you
Blindness/Cataract			
Glaucoma			
Crossed Eyes			
Macular Degeneration			
Retinal Detachment/Disease			
Arthritis			
Cancer			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lupus			
Diabetes			
Thyroid Disease			
Other			

Social History

Have you ever used tobacco products? No Yes If yes, type/amount/how long:_____

Do you drink alcohol? No Yes If yes, type/amount/how long:_____

Allergies and Medications

List any allergies you have (including medications, environmental, food): _____

List any medications you take (including oral contraceptives, aspirin, over the counter, vitamins):

_____

_____

Visual Demands

Computer use: Hours/day: ____ Number of monitors and type (desktop, laptop): _____

Please explain any special visual demands you have at work, home or play: _____

_____

Nutrition/Diet

Do you have any food allergies or sensitivities: No Yes If yes, list them: _____

Lifestyle

Are you experiencing: Sleep issues _____ Eating issues _____Digestive issues _____ Do you drive:? No Yes

Do you play sports or exercise on a regular basis? Yes No What do you do?_____