NEW

PLEASE READ & COMPLETE ALL QUESTIONS

All Information is Strictly Confidential.

Name _____Date of Birth_____
Preferred Name _____SS# if using insurance _____
Address_____ City/State/ ZIP_____
Phone #_____E-mail _____

Thank you for choosing The Eye Center! Please choose your primary reason for today's visit:

- ○ Annual eye exam
- ○ Annual exam for contact lenses
- ○ Diabetic eye exam
- ○ Eye Injury *(please explain)* _____
- ○ Follow up/Testing _____

Additional concerns_____
When was your last eye exam? _____

Glasses:
Do you wear glasses? ☐Yes ☐No Are you interested in new glasses? ☐Yes ☐No
How old are your current glasses? _____
Are you interested in trying contacts? ☐Yes ☐No
If you have worn contacts before, but discontinued wear, please explain:
_____

Contact lenses:
What brand of contacts are you currently in? _____
On a scale of 1 -10 (10 being the best) how would you rate the comfort of your lenses? _____
When do you change your contact lenses? ☐ Daily ☐ Bi-Weekly ☐Monthly ☐ Other(explain)_____
How many nights a week do you sleep in your lenses? _____

Diabetic patients:
Prescribing Physician _____
Physician's Tel # _____ Fax# _____
Current A1C _____ Current Blood Sugar _____ Years Diabetic _____
Diabetes Mellitus: Type 1 Type 2 Pre-diabetic

Glaucoma patients:
Have you been diagnosed with glaucoma? ☐Yes ☐No
If so, by whom and when? _____Which eyes are affected?_____
Would you like The Eye Center to manage your glaucoma care? ☐Yes ☐No
If not, who manages your glaucoma? _____
What drops do you take, and when do you take them? _____
List any side effects associated with your drops: _____

Migraine patients: Please answer only if diagnosed by physician
Prescribing Physician _____
How often? _____ How many years? _____
Circle all of the associated symptoms: loss of vision / nausea / fainting / floaters / aura or flickering lights
List all at home and/or prescribed migraine management and how long you have been taking them:
_____

NEW

Medical History: IF YOU DO NOT KNOW THE NAMES OF YOUR MEDICATIONS PLEASE INDICATE WHAT THEY ARE FOR

List ALL medications (eye and non-eye related including over the counter medications):
_____
_____

List why you are taking medications listed AND any other medical conditions (whether taking medication or not):
_____
_____

List all EYE related injuries, surgeries, and medical diagnoses (macular degeneration, detachments, etc.) & when they occurred:
_____

Are you currently **pregnant** or nursing? ☐ Yes ☐ No

Do you have **Sleep Apnea**? ☐ Yes ☐ No
If yes, do you sleep with a CPAP machine?☐ Yes ☐ No

Social History:
Do you use tobacco products? ☐ Yes ☐ No If yes, type/amount/ how long: _____
Do you drink alcohol? ☐ Yes ☐ No If yes, type/amount/ how long: _____

Hobbies and Activities:
☐Computers ☐Sports_____ ☐Reading ☐Biking ☐Fishing ☐Sewing
Other _____
What kind of work do you do? _____

Immediate Family History (Check members who apply):

	Father	*Mother*	*Brother*	*Sister*	*Son*	*Daughter*
Cancer						
Diabetes						
Thyroid Issues						
High Blood Pressure						
Macular Degeneration						
Cataracts						
Glaucoma						

Allergies:
Medicine allergies _____
Food allergies _____
Other _____
Do you have seasonal allergies? ☐ Yes ☐ No Are you sensitive to latex? ☐ Yes ☐ No

FOR PATIENT USE

Lifestyle Index

FOR OFFICE USE

PT INITIALS _____

DATE _____

This survey is meant to help your doctor understand what you're experiencing on a regular basis — **whether it's caused by your eyes, posture, stress, etc**. Your responses will help make sure you receive the best care possible.

How often do you experience any of these symptoms? Circle one:

Headaches

- You get headaches of any severity each week (even just a dull ache counts).
- Your headaches tend to get worse later in the day.
- Your headaches are generally worse at work than they are at home or on weekends.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Stiffness / pain in neck / shoulders

- Your neck gets stiff and sore when you work at a computer or read (This might even be from your posture).
- You experience frequent tension in your head, neck or shoulders.
- You get frequent massages/chiropractic adjustments.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Discomfort with Computer Use

- You feel like you are more productive at work in the morning vs. the afternoon.
- Your eyes get tired, burn, or get red easily when you work at a computer for long hours.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Number of hours per day using a digital device: _____

Tired Eyes

- Your eyes feel fatigued/tired at the end of a workday.
- Your eyes generally feel better in the morning compared to the end of the day.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Dry Eye Sensation

- Your eyes and/or contacts tend to dry out when you are working at a computer or reading.
- Your eyes progressively feel more dry/sandy/gritty as the day goes on.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Light Sensitivity

- Driving at night is difficult because of glare from highlights.
- Fluorescent lights bother you in large spaces (grocery store, department store, etc.).

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Dizziness

- Riding in a car gives you motion sickness.
- You sometimes feel a sensation of vertigo or disconnectedness from your environment.

1	2	3	4	5
Never	Rarely	Sometimes	Very Often	Always

Additional Notes

Any additional notes about these symptoms: _____

_____

FOR DOCTOR / STAFF USE

DATE _____ SYNC (DIST) _____ ESO EXO SYNC (NEAR) _____ ESO EXO SYNC (RX) _____ BI BO R ☐