

ALLISONVILLE EYE CARE CENTER

Name _____ DOB ____/____/____ Date ____/____/____

Primary Care Physician:

Name _____
Address _____
Phone _____

Other Specialist/Physician:

Name _____
Address _____
Phone _____

When was your last eye exam? _____

Referred by: _____

YES NO

____ Do you wear glasses? Please circle: Distance / Computer / Near / Full-time / Part-time
____ Do you wear contact lenses? Yes / No _____ # days per week / Brand _____

Please list any prescription or non-prescription medications you are taking:

Please list any prescription or non-prescription eye drops you are using:

YOUR OCULAR HISTORY- Please give details on any YES answer.

YES NO

____ History of Eye Injury or Eye Infection _____
____ History of Eye Disease _____
____ History of a Crossed or Out-turned Eye _____
____ History of Eye Surgery (Give dates if possible) _____
____ Do you have a family history of Glaucoma or Macular Degeneration? _____
____ Do you smoke? _____ # packs per day
____ Do you drink alcohol? _____ # of drinks per day/week
____ Do you have any communicable disease? _____
____ If female, are you pregnant or nursing? Due Date _____

PERSONAL MEDICAL HISTORY- Please indicate whether there is a history of problems in each category.

YES NO (NOT FAMILY HISTORY)

____ Cancer _____
____ Allergies (Seasonal / Year-round / Medications) _____
____ Cardiovascular (High Blood Pressure / Heart Disease / Circulation Problem / Stroke) _____
____ Constitutional difficulties (general feeling of wellness) _____
____ Diabetes (Yr./Yrs. Diagnosed _____) / Increased Cholesterol / Gout / Low Thyroid / Hyperthyroid _____
____ Gastrointestinal /Stomach _____
____ Genitourinary _____
____ Head (Ear / Nose / Throat Disorder / Headaches / Migraines / Sinus Problems) _____
____ Blood Disease / Lymphatic _____
____ Immunologic _____
____ Skin _____
____ Musculoskeletal (Arthritis) _____
____ Neurological _____
____ Psychiatric / Depression _____
____ Respiratory _____
____ Other _____