FOR YOUR

EYES

ONLY

OPTOMETRY CENTER

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PATIENT INFORMATION

Name:________________________ Date of Birth:__________ Age:_____ Sex: __________

Phone: ________________________ □Home □Cell □Work Email:______________

Address:________________________ City:______________ State:____ Zip:__________

Employer:________________________ Occupation:______________________________

Primary medical insurance: ______________________________ ID #: ______________

Is Responsible Party the patient? □ Yes □ No *if no complete below*

*Name, phone and relation to responsible party:*______________________________

OCULAR HISTORY

List any drops prescribed or over the counter you use: ______________________

Circle "S" for self and/or "F" for family member for all conditions that apply

S / F - lazy eye S / F - cataracts S / F - macular degeneration S / F - eye infection
S / F - glaucoma S / F - eye injuries S / F - retinal disease S / F - drooping eyelid

Other (indicate self or family): ______________________________

List all ocular procedures you have had and when: ______________________________

Date of last eye exam: __________ Name of practice and/or doctor: ______________________

Do you wear glasses? □ Yes □ No *if yes how old is your present pair?* ______________

Do you wear contacts? □ Yes □ No *if yes please complete below*

*Brand or type of contact if not soft:*______________________ *Average daily wear time:* _____*hrs*

Power: R ______________ *L* ______________ *Solution used:*__________

MEDICAL HISTORY

Date of last physical exam: ________ Name of practice and/or doctor: ______________________

List all allergies to medications or substances as well as reactions:

____

List all over the counter medications, prescribed medications, and/or supplements you use:

____

List all major injuries, surgeries and/or hospitalizations you have had:

____

Circle if one applies: pregnant nursing

Circle "S" for self and/or "F" for family member for all conditions that apply

S / F - hypertension S / F - respiratory disease S / F - rheumatoid arthritis S / F - diabetes I
S / F - hypercholesterolemia S / F - heart disease S / F - thyroid dysfunction S / F - diabetes II

Other (indicate self or family): ______________________________

Diabetics only: *Last known A1C & date:* ____________ *Last measured blood sugar & date* ____________

SOCIAL HISTORY

Do you drive? ◻ Yes ◻ No *if yes and you experience difficulty describe below*

____

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:* ______________________

Do you use marijuana? ◻ Yes ◻ No *if yes, type/amount/how long:* ______________________

Do you use illegal drugs? ◻ Yes ◻ No *if yes, type/amount/how long:* ______________________

Have you ever been infected with any of the following? ◻ Gonorrhea ◻ Hepatitis ◻ HIV ◻ Syphilis ◻ No

REVIEW of SYSTEMS

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

SYSTEMS	Yes	No	?
Constitutional			
Fever, weight loss/gain	◻	◻	◻
Skin	◻	◻	◻
Neurological			
Headaches	◻	◻	◻
Migraines	◻	◻	◻
Seizures	◻	◻	◻
Eyes			
Loss of Vision	◻	◻	◻
Blurred Vision	◻	◻	◻
Distorted Vision	◻	◻	◻
Loss of side vision	◻	◻	◻
Double vision	◻	◻	◻
Dryness	◻	◻	◻
Mucous discharge	◻	◻	◻
Redness	◻	◻	◻
Sandy or gritty feeling	◻	◻	◻
Itching	◻	◻	◻
Burning	◻	◻	◻
Foreign body sensation	◻	◻	◻
Excess tearing	◻	◻	◻
Glare/light sensitivity	◻	◻	◻
Eye pain/soreness	◻	◻	◻
Chronic infection	◻	◻	◻
Stye/chalazion	◻	◻	◻
Flashes/floaters in vision	◻	◻	◻
Tired eyes	◻	◻	◻
Endocrine			
Thyroid/other gland	◻	◻	◻

SYSTEM	Yes	No	?
Ears, Nose, Mouth, Throat			
Allergies/Hay fever	◻	◻	◻
Sinus congestion	◻	◻	◻
Runny Nose	◻	◻	◻
Post-Nasal Drip	◻	◻	◻
Chronic Cough	◻	◻	◻
Dry Throat	◻	◻	◻
Respiratory			
Asthma	◻	◻	◻
Chronic bronchitis	◻	◻	◻
Emphysema	◻	◻	◻
Vascular/cardiovascular			
Diabetes	◻	◻	◻
Heart pain	◻	◻	◻
High blood pressure	◻	◻	◻
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	◻	◻	◻

Other: ____

____

I understand that if my insurance cannot provide prior guarantee of payment, I will be responsible for all charges incurred at the time of service. I hereby authorize For Your Eyes Only Optometry Center to release information applicable to benefits payable for services.

Signature: ______________________________ Date: ______________________

(parent's signature if patient is a minor)