Thank you for choosing our practice for your eyecare needs. To update our records please fill out the information below. If you have any questions or concern please feel free to ask for assistance, we are happy to help.

Last name_____. First name_____. Email_____.

Family History: Does anyone in your immediate family (blood relative) have a history of the following? If YES, Who?

- ○Y ○N Diabetes
- ○Y ○N Glaucoma
- ○Y ○N Blindness
- ○Y ○N Cataracts
- ○Y ○N Heart Condition
- ○Y ○N High Blood Pressure
- ○Y ○N Macular Degeneration
- ○Y ○N Thyroid Difficulty
- ○Y ○N Turned or Lazy Eye
- ○Y ○N Retinal Detachment

Review of Systems:

What is your general health?_____ Date of Last Physical?_____ Doctors Name?_____

Past Operations: Kind? When? _____

Please circle any of the following that applies to you, If it is not listed please explain.

Neurological
Seizures
_____

Gastrointestinal
IBS
When?_____

Psychiatric
Anxiety

Environmental Allergies/ Medication Allergies
To what?_____

Cardiovascular
Irregular Heartbeat
_____

Genito-Urinary
_____

Blood/Lymph
Blood Disorder
_____

Integumentary
Skin Cancer
When?_____

Endocrine (glands)
Diabetic? Type I or II
Thyroid difficulty
_____

Musculoskeletal
Arthritis
_____

Ear/Nose/Throat
Sinus Trouble
Hard of Hearing
_____

Respiratory
Asthma
_____

Current Medications: _____

USE OF: Alcohol ? **Y N OCC**
Cigarettes/Tobacco? **Y N OCC**
Other Substances? **Y N OCC**

Eyes, have you ever had any of the following?

Eye surgery? When?_____.
Eye injury? When?_____.
Sensitivity to light
Floaters or spots
Poor distance vision
Poor near vision
Eye infection or disease
Double vision
Flashes
Dry eyes
Pain
Eye strain
Itching/Burning eyes
Eye fatigue
Sandy, dry or gritty eyes

Other eye problems _____

Have you ever worn **Glasses**? **Y N** If yes, when? _____

Contact Lens? **Y N** If yes, when? _____

Have you noticed any change in your vision? **Distance? Yes. or No**
Near? Yes or No

Date of last eye exam? _____ Doctors Name_____

Updated By:_____ Date_____