Today's Visit

TODAY'S INTERESTS: ☐**NEW GLASSES** ☐ **NEW CONTACTS** ☐ **LASIK**

What is the specific reason(s) for your visit today?

Occupation: «Occupation» **Do you drive?** ☐ Yes ☐ No

Currently Wearing: ☐ NONE ☐ **GLASSES** for: ☐Distance ☐Near ☐**CONTACTS**

Do you have special visual needs at work or home? ☐Computers ☐Small Print/Detail ☐Safety ☐Sports

☐ Other? ________________________________

Personal Medical History

1. General Health: ☐Fever ☐Fatigue ☐Trauma ☐Weight Change ☐Developmental Disability ☐Other (explain)

☐Pregnant: Due Date: ☐Breastfeeding

☐ **Normal**

2. Eyes: ☐Blur ☐Dist. ☐Near ☐Double ☐Fatigue/Tired ☐Dry ☐Pain ☐Cataracts ☐Glaucoma ☐Macular Degen. ☐Retinal Detach. ☐"Lazy Eye" ☐Previous Infection / Injury ☐Other (explain)

☐ **Normal**

3. Endocrine: ☐Thyroid Dysfunction ☐Hormone Dysfunction

☐Diabetes: Type: ☐ 1 ☐ 2 ☐Controlled ☐Poor Control

Year Diagnosed:_________ Average Glucose:______

Last A1C (level / date): ☐Other (explain)

☐ **Normal**

4. Cardiovascular: ☐Heart disease ☐High Blood Pressure ☐Vascular Disease ☐High Cholesterol ☐Other (explain)

☐ **Normal**

5. Neurological: ☐Stroke ☐Epilepsy ☐Multiple sclerosis ☐Headaches ☐Other (explain)

☐ **Normal**

6. Ears, Nose, Mouth & Throat: ☐Cold ☐Flu ☐Infection ☐Cancer ☐Other (explain)

☐ **Normal**

7. Lungs: ☐Asthma ☐Bronchitis ☐Emphysema ☐Cancer ☐Other (explain)

☐ **Normal**

8. Stomach / Gut: ☐Crohn's ☐Colitis ☐Ulcer ☐Cancer ☐Other (explain)

☐ **Normal**

9. Genitourinary / Breast: ☐Kidney Ailments ☐Cancer ☐STD: Herpes, Chlamydia, HIV ☐Other (explain)

☐ **Normal**

10. Musculoskeletal: ☐Fibromyalgia ☐Muscular dystrophy ☐Osteoarthritis ☐Other (explain)

☐ **Normal**

11. Skin: ☐Eczema ☐Rosacea ☐Psoriasis ☐Cancer ☐Other (explain)

☐ **Normal**

12. Psychiatric: ☐Depression ☐Anxiety ☐Panic disorder ☐Schizophrenia ☐Bipolar ☐Other (explain)

☐ **Normal**

13. Blood / Lymphatic: ☐Anemia ☐Leukemia ☐Other (explain)

☐ **Normal**

14. Allergic / Immunologic: ☐Seasonal Allergy ☐Lupus ☐Rheumatoid Arthritis ☐Other (explain)

☐ **Normal**

Other:

Personal Social History

Tobacco product use?	Drink alcohol?	Illegal drugs use?
☐ No ☐ Yes. If yes, complete below.	☐ No ☐ Yes. If yes, complete below.	☐ No ☐ Yes. If yes, complete below.
Type: ☐ Cigarette ☐ _____________	Type: ☐ Beer ☐ Wine ☐ __________	Type:
Amount:	Amount:	Amount:
How long:		

Personal Medication and Surgery History

Current Medications (include non-prescription): ____

____

____

____

____

Medication Allergies: ☐ None ☐ Penicillin ☐ Sulfa ☐ Other: ____

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____

Major Surgeries and Dates:____

____

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Family Medical History

☐ **No Family Medical History**

☐ Cataracts	☐ Glaucoma	☐ Diabetes
☐ Retinal Detachment	☐ Macular Degeneration	☐ Heart Disease
☐ “Lazy Eye”	☐ Other Eye Disease	☐ Other Hereditary Disease (explain)

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