Name: _____ Date: _____
E-Mail Address _____
Would you like to have the Optomap today? ◯ No ◯ Yes ◯ I would like to speak to the doctor
When was your last physical exam (including blood work)? _____ HbA1c _____
Who is your primary Care Physician (Name, address, and phone number if possible)
_____
What is your current: Height _____ Weight _____
*New Patients***:** When was your last comprehensive eye exam? _____

Race
◯ Asian ◯ Native American
◯ Black ◯ Caucasian
◯ Other ◯ Refuse to specify

ETHNICITY
◯ Hispanic
◯ Non-Hispanic
◯ Other _____

What is your preferred language?
◯ English ◯ Spanish ◯ French ◯ Italian ◯ Russian ◯ Portuguese

Occupation: _____ How many years? _____ Employer: _____

Social History
Do you drink alcohol? ◯ No ◯ Occ ◯ 1 Per Day ◯ 2-3 Per Day ◯ 4+ Per Day
Do you smoke? ◯ No ◯ Yes ◯ ½ Pack/Day ◯ 1 Pack/Day ◯ 1+ Pack/Day
Past smoker ◯ No ◯ Yes When did you quit smoking? _____
Do you chew tobacco? ◯ No ◯ Yes
Do you use nutritional supplements? ◯ No ◯ Yes
Do you engage in regular exercise? ◯ No ◯ Yes
Hobbies / Interest? _____

Visual History
Computer used? ◯ No ◯ Yes How many hours/day? _____ Distance from computer? _____
Do you drive? ◯ No ◯ Yes Daily mileage? _____
Do you have glare problems? ◯ No ◯ Yes
Do you have visual difficulty when driving? ◯ No ◯ Yes
Do you have problems with night vision? ◯ No ◯ Yes

Glasses
Do you currently wear glasses? ◯ No ◯ Yes Since: _____
Type of glasses: ◯ Full Time ◯ Part Time ◯ Distance ◯ Close
Glasses Owned: ◯ Single Vision ◯ Bifocals ◯ Trifocals ◯ Backup ◯ Safety
◯ Sports ◯ Progressive
Have you had trouble in the past with glasses? ◯ No ◯ Yes _____
Do you wear sunglasses? ◯ No ◯ Yes
Are your sunglasses your current prescription? ◯ No ◯ Yes

Contact Lens History
Have you ever tried to wear contact lenses? ◯ No ◯ Yes Reason for stopping? _____
If you are not a contact lens wearer, are you interested in trying contacts at this time? ◯ No ◯ Yes
Do you currently wear contact lenses? ◯ No ◯ Yes Since: _____
Type and brand of contacts: _____
How many hours per day? _____ How many days per week? _____ How long today? _____
Cleaner: _____ Disinfectant: _____ Enzyme: _____

Medication
List any drug allergies: _____
List allergic reaction: _____

List current medications/dosage:
_____
_____
_____

Past surgeries/dates/surgeon:
_____
_____

Eye Disease
◯ Amblyopia (lazy eye)
◯ Blepharitis
◯ Blindness
◯ Cataract
◯ Color Blindness
◯ Diabetic Retinopathy
◯ Dry Eye Syndrome
◯ Eye Injuries
◯ Glaucoma
◯ Glaucoma Suspect
◯ High Risk Medication
◯ Macular Degeneration
◯ PVD
◯ Retinal Detachment
◯ Strabismus (eye turn)
◯ Other

Current Eye Symptoms
◯ Glare Sensitivity
◯ Headaches
◯ Light Sensitivity
◯ Tired Eyes
◯ Burning
◯ Dryness
◯ Epiphora
◯ Eyelid Swelling
◯ Eye Pain/Soreness
◯ Foreign Body Sensation
◯ Infection of Eye Lid
◯ Itching
◯ Mucus
◯ Ptosis (drooping eyelid)
◯ Redness
◯ Sandy or Gritty Feeling
◯ Other

Visual Symptoms
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision
◯ Double Vision
◯ Flashes of Light
◯ Floaters or Spots
◯ Fluctuating Vision
◯ Loss of Central Vision
◯ Loss of Side Vision
◯ Loss of Vision
◯ Other

Review of Systems
◯ Constitutional Symptom**s** (fever, weight loss, etc.)
◯ Ears, Nose, Throat
◯ Cardiovascular (heart, hypertension)
◯ Respiratory (asthma, emphysema, etc.)
◯ Gastrointestinal
◯ Genital, Kidney, Bladder
◯ Muscles, Bones, Joints (arthritis, etc.)
◯ Skin (acne, skin cancer, etc.)
◯ Neurological (multiple sclerosis, etc.)
◯ Psychiatric (anxiety, depression, etc.)
◯ Endocrine (diabetic, hypothyroid, etc.)
◯ Blood/Lymph (anemic, cholesterol, etc.)
◯ Allergic/Immunologic (seasonal allergies, lupus, etc.)
◯ Pregnant
◯ Nursing

Family History (indicate father, mother*, paternal/maternal* grandmother, *paternal/maternal* grandfather, etc.)
◯ Amblyopia (lazy eye) _____
◯ Blindness _____
◯ Cataract _____
◯ Color Blindness _____
◯ Eye Tumor _____
◯ Glaucoma _____
◯ Glaucoma Suspect _____
◯ Macular Degeneration _____
◯ Retinal Detachment _____
◯ Strabismus (eye turn) _____
◯ Arthritis _____
◯ Cancer _____
◯ Diabetes _____
◯ Heart Disease _____
◯ High Blood Pressure _____
◯ Kidney Disease _____
◯ Lupus _____
◯ Stroke _____
◯ Thyroid Disease _____
◯ Other Disease _____
◯ Other _____