Vision/Medical History	Form Rev. 3/18/13	Today's Date / /

Name_____ Date of Birth _____ Age _____
Last First MI

Your occupation _____ or if a student - current school grade _____

On average, how many hours/day do you spend looking at electronic screens - computers, PDAs, Kindles, iPads, cell phones, etc? _____

On average, how many hours/day do you spend looking at hard copy print - books, newspapers, reports, etc? _____

Visual tasks, Hobbies, Sports (Check and add all that apply)

❑ Baseball	❑ Computers	❑ Golf	❑ Reading	❑ Tennis
❑ Basketball	❑ Crafts	❑ Hunting	❑ Shooting	❑ Woodworking
❑ Billiards	❑ Fishing	❑ Piano/Organ	❑ Skiing-Snow/Water	❑ _____
❑ Boating	❑ Gardening	❑ Racquetball	❑ Swimming	❑ _____

Do you wear glasses? ❑ Yes ❑ No Date of last eye exam _____ Previous eye doctor _____

Do you wear contact lenses? ❑ Yes ❑ No If yes, what type/brand? _____

If no, are you interested in wearing contact lenses for vision correction and/or eye color change? ❑ Yes ❑ No ❑ Maybe

Are you interested in information on Laser Vision Correction? ❑ Yes ❑ No ❑ Maybe

How did you hear about us? Who may we thank for recommending us? (Please check one.)
___Relative ___Friend ___Nurse ___Doctor Who may we thank?_____
___Yellow pages ___Coupon ___Insurance company listing ___Newspaper Ad – Which paper?_____

REVIEW OF SYSTEMS DO **YOU** TAKE MEDICATION FOR, OR HAVE **YOU** HAD ANY PROBLEMS OR TREATMENT OF ANY KIND FOR ANY OF THE FOLLOWING CONDITIONS WITHIN THE PAST TWO YEARS:

SYSTEM	**YES**	**NO**
CONSTITUTIONAL		
Fever, Weight changes, Fatigue	❑	❑
CARDIOVASCULAR		
Heart Disease	❑	❑
High Blood Pressure	❑	❑
Vascular Disease	❑	❑
High Cholesterol	❑	❑
EARS, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	❑	❑
Sinus Congestion	❑	❑
Runny Nose, Post Nasal Drip	❑	❑
Chronic Cough	❑	❑
Dry Throat/Mouth	❑	❑
RESPIRATORY		
Asthma	❑	❑
Chronic Bronchitis	❑	❑
Emphysema	❑	❑
GASTROINTESTINAL		
Diarrhea	❑	❑
Constipation	❑	❑
GENITOURINARY		
Genitals/Urinary/Bladder	❑	❑

	YES	**NO**
MUSCULOSKELETAL		
Osteo or Rheumatoid Arthritis	❑	❑
Muscle Pain	❑	❑
Joint Pain	❑	❑
INTEGUMENTARY (SKIN)		
Rosacea	❑	❑
Skin cancers	❑	❑
NEUROLOGICAL		
Headaches	❑	❑
Migraines	❑	❑
Seizures	❑	❑
PSYCHIATRIC		
Depression/Anxiety	❑	❑
Bipolar disorders	❑	❑
ENDOCRINE		
Diabetes	❑	❑
Thyroid/Other Glands	❑	❑
HEMATOLOGIC / LYMPHATIC		
Anemia	❑	❑
Bleeding Problems	❑	❑
ALLERGIC / IMMUNOLOGIC		
Autoimmune disorders	❑	❑

If you answered YES to any of the above and would like to expand or clarify or have a condition not listed, please explain:

_____

_____

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

_____

****** PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE ******

Primary care physician _____ Date of last physical examination _____

Address _____ City _____ CT Zip _____

Phone _____ Fax _____

MEDICATIONS

List **any and all** medications you take - of any kind, for any reason (including oral contraceptives, aspirin, recreational drugs, medicated skin creams, inhalers, over the counter medications, and home remedies - or attach list)

❑ None _____

_____

_____

Are you allergic to any medications? ❑ Yes ❑ No If yes, explain: _____

EYE CONDITIONS DO **YOU** CURRENTLY, OR HAVE **YOU** HAD ANY PROBLEMS OR TREATMENT OF ANY KIND FOR THE FOLLOWING EYE CONDITIONS :

DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO	DISEASE/CONDITION	YES	NO
Glaucoma	❑	❑	Amblyopia / Lazy Eye	❑	❑	Drooping Eyelid	❑	❑
Cataracts	❑	❑	Dry Eye	❑	❑	Prominent / Bulging Eyes	❑	❑
Macular Degeneration	❑	❑	Flashes / Floaters in Vision	❑	❑	Mucous / Pus Discharge	❑	❑
Eye Injury	❑	❑	Tired Eyes	❑	❑	Eye Redness	❑	❑
Retinal Detachment	❑	❑	Loss of Side Vision	❑	❑	Eye Itching	❑	❑
Other Retinal Disease	❑	❑	Double Vision	❑	❑	Excess Tearing / Watering	❑	❑
Loss of Vision/Blindness	❑	❑	Eye Surgery	❑	❑	Chronic Infection of Eye or Lid	❑	❑
Eye Turn / Strabismus	❑	❑	Distorted Vision / Halos	❑	❑	Styes or Chalazion	❑	❑

If you answered YES to any of the above and would like to expand or clarify or have an eye condition not listed, please explain:

_____

_____

FAMILY HISTORY DOES ANY **BLOOD RELATIVE** HAVE A DIAGNOSIS OF OR RECEIVE TREATMENT FOR ANY OF THE FOLLOWING CONDITIONS?

DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU	DISEASE/CONDITION	YES	NO	RELATIONSHIP TO YOU
Glaucoma	❑	❑		Diabetes	❑	❑	
Cataract	❑	❑		Cancer	❑	❑	
Macular Degeneration	❑	❑		Heart Disease	❑	❑	
Retinal Detachment	❑	❑		High Blood Pressure	❑	❑	
Other Retinal Disease	❑	❑		High Cholesterol	❑	❑	
Amblyopia / Lazy Eye	❑	❑		Thyroid Disease	❑	❑	
Blindness	❑	❑		Rheumatoid Arthritis	❑	❑	
Strabismus / Eye Turn	❑	❑		Lupus	❑	❑	
Other Eye Disease	❑	❑		Other	❑	❑	

SOCIAL HISTORY *This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Do you drive? ❑ Yes ❑ No If yes, do you have visual difficulty when driving? ❑ Yes ❑ No If yes, please describe:

_____

Do you use tobacco products? ❑ Yes ❑ No If yes, type/amount/how long: _____

Do you use recreational drugs? ❑ Yes ❑ No If yes, type/amount/how long: _____

Do you drink alcohol? ❑ Yes ❑ No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with tuberculosis, hepatitis, HIV, gonorrhea, syphilis, or any other potentially contagious condition?

❑ Yes ❑ No If yes, please specify _____

Are you pregnant or nursing? ❑ Yes ❑ No or N/A