EYE TRENDS

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Therapeutic Optometrists and Optometric Glaucoma Specialists

Date	**Insurance**

Patient Name:			**Gender :**	**D.O.B.:**
Home #:	**Mobile:**	**Email:**		
Home Address:			**SSN:**	
City:	**State:**	**Zip:**	**Driver's License:**	
Occupation:		**Employer:**		

How did you hear about us? (please circle): family, friend, doctor, website, walk-in, yellow pages, other:_____

Medical History

Do you have any allergies to medications? N__ or Y__
If yes, which?_____
_____
Are you pregnant and/or nursing? N __ or Y__

List any medications you take: (include over the counter) _____
_____
_____
_____
_____

Your Visual Complaints

Please check if you have …

- ☐ Blur at distance and near
- ☐ Distance vision blurry
- ☐ Near vision blurry
- ☐ Bump on lid
- ☐ Burning eyes
- ☐ Crusty
- ☐ Discharge
- ☐ Double vision
- ☐ Dry eyes
- ☐ Eyelids twitching
- ☐ Eye pain
- ☐ Eye irritation
- ☐ Eye strain
- ☐ Pressure behind eye
- ☐ Flashing lights
- ☐ Black spots or floaters
- ☐ Foreign body sensation
- ☐ Headaches related to eyes
- ☐ Injury
- ☐ Itching eyes
- ☐ Light sensitivity
- ☐ Temporary loss of vision
- ☐ Redness
- ☐ Watery Eyes
- ☐ Wavy lines
- ☐ None – routine exam

Your Eye Health History

Please check if you have …

- ☐ Allergies
- ☐ Amblyopia
- ☐ Macular Degeneration
- ☐ Cataracts
- ☐ Glaucoma
- ☐ LASIK
- ☐ Lazy Eye/ Turned Eye (strabismus)
- ☐ Retinal Detachment
- ☐ Surgery (cataract or other)
- ☐ Trauma/ Injury
- ☐ Other:_____

Your Medical Health History

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer:_____
- ☐ Diabetes: how long ____
- ☐ Drug Sensitivity
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AID
- ☐ Inflammatory disease
- ☐ Infectious disease

Your Medical History continued

- ☐ Kidney disease
- ☐ Lung disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Skin Condition
- ☐ Thyroid Condition
- ☐ Tuberculosis
- ☐ Other:_____

Family Health and Eye History

Please check all applicable items …

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Hay Fever
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Migraines
- ☐ Amblyopia
- ☐ Macular degeneration (ARMD)
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Lazy Eye
- ☐ Retinal Detachment
- ☐ Blindness

Review of Systems Please circle Y if the following apply to you:

Allergic/Immunologic		***Gastrointestinal continued***		***Blood***	
Hay Fever	N Y	Vomiting	N Y	Anemia	N Y
Drug or Food Allergies	N Y	Stomach ulcer	N Y	Easy bruising	N Y
Seasonal Allergies	N Y	***General/Constitutional***		Bleeding Problems	N Y
Cardiovascular		Weight loss	N Y		
Chest pain (Angina)	N Y	Weight gain	N Y	***Musculoskeletal***	
Irregular heartbeats	N Y	Fever or chills	N Y	Joint pain	N Y
High Blood Pressure	N Y	Very tired	N Y	Muscular weakness	N Y
High Cholesterol	N Y	***Genitourinary***		Cramps	N Y
Heart Attack	N Y	Increased uriniation	N Y	Limitation in motion	N Y
Ears/Nose/Mouth/Throat		Urination at night	N Y		
Hearing Loss	N Y	Incontinence	N Y	***Neurological***	
Nose bleeding	N Y	STD's	N Y	Tremors	N Y
Nose obstruction	N Y	Genitals/Kidney/Bladder	N Y	Dizziness/ vertigo	N Y
Dental difficulties	N Y	Change urinary strength	N Y	Numbness	N Y
Neck Stiffness	N Y	Dialysis	N Y	Seizures	N Y
Endocrine		Hematuria	N Y	Head Injury	N Y
Heat or cold intolerance	N Y	Kidney Stones	N Y	Migraines	N Y
Sweating	N Y	Menopause	N Y		
Frequent urination	N Y	Urinary tract infection	N Y	***Psychiatric***	
Thirst (polydypsia)	N Y	***Integumentary/ Skin***		Depression	N Y
Change in appetite	N Y	Easy bleeding	N Y	Anxiety	N Y
Diabetes Type I	N Y	Rashes	N Y	Hallucinations	N Y
Diabetes Type II	N Y	Hair growth/loss	N Y	***Respiratory***	
Gastrointestinal		Dryness	N Y	Shortness of breath	N Y
Acid Reflux	N Y	Pigmentation changes	N Y	Asthma	N Y
Diarrhea	N Y	Itchiness	N Y	Chronic cough	N Y
Blood in stool	N Y				

Social History *This information is kept strictly confidential however if you wish to discuss this directly with your doctor check here:*

Do you drink more than 2-3 alcoholic drinks/ day? N Y

Do you use tobacco products regularly? N Y Do you use illegal drugs? N Y

Date of last physician visit	Physician's name w/ phone
Date of last eye exam	Previous eye doctor

Do you wear glasses? N Y How old is your current pair?_____

Have you ever worn contacts ? N Y How old is your present pair?_____

Type of contact lenses (please circle)? Dailies, 2-week, monthly, quarterly, conventional (reusable), bifocal, colored, hard / gas permeable, torics (for astigmatism) Brand:_____

Do you sleep in your lenses? N Y

Pupil Dilation

In order to examine the entire eye, we must dilate the pupil. Examining the eye is like trying to look into a room through a keyhole. By enlarging the pupil, the doctor is able to clearly see the areas within the eye. Gentler drops now provide the means for a quick, painless examination with minimal side effects. You may experience a temporary dryness of the eye, some blurring of near vision, and some light sensitivity for a period of three to five hours. Many types of eye disease and injury can go undetected without dilation. As with any disease, early diagnosis is essential to successful treatment and prevention of future complication.

May we have your permission to dilate your eyes?

Yes No Will discuss with doctor Signature_____

Patient/ Guardian's Signature Date