Optometric Associates Patient Intake Form Today's Date: _____ Doctor: _____

PATIENT: _____ **DOB:** _____ **EMAIL:** _____

CHIEF COMPLAINT

How can we help you today? In the space below please briefly tell us any signs and symptoms you are experiencing such as loss of vision, headaches, eye redness, eye pain, eye itching or burning, floaters, or dryness.

Your current HEIGHT: _____
Your current WEIGHT: _____
Marital status: SINGLE [ ] MARRIED [ ] OTHER [ ]

[ ]Y [ ] N Are you thinking of new glasses today?
[ ]Y [ ] N Are you interested in new contact lenses today?

EYE CONDITIONS: Have you had or been diagnosed with any of the following conditions?

Cataracts	[ ] Y [ ] N	Eye infection or inflammation	[ ] Y [ ] N
Age related macular degeneration	[ ] Y [ ] N	Floaters and/or flashes of light	[ ] Y [ ] N
Glaucoma	[ ] Y [ ] N	Iritis or Uveitis	[ ] Y [ ] N
Diabetes	[ ] Y [ ] N	Retina defects or degenerations	[ ] Y [ ] N
Diabetic retinopathy	[ ] Y [ ] N	Blindness	[ ] Y [ ] N
Dry eye	[ ] Y [ ] N	Other (please list):	[ ] Y [ ] N
		_____	

VISUAL CONCERNS: Are you having any of the following eye concerns?

Redness	[ ] Y [ ] N	Eye Pain	[ ] Y [ ] N
Burning	[ ] Y [ ] N	Light Sensitivity	[ ] Y [ ] N
Itching	[ ] Y [ ] N	Headache	[ ] Y [ ] N
Tearing OR watering	[ ] Y [ ] N	Poor night vision	[ ] Y [ ] N
Discharge	[ ] Y [ ] N	Bothersome night glare	[ ] Y [ ] N
Fluctuating vision	[ ] Y [ ] N	Double vision	[ ] Y [ ] N
Eye Strain	[ ] Y [ ] N	Loss of vision	[ ] Y [ ] N

Have you ever been exposed to or infected with:	
Gonorrhea	[ ] Y [ ] N
Hepatitis	[ ] Y [ ] N
HIV	[ ] Y [ ] N
Syphilis	[ ] Y [ ] N
Tuberculosis	[ ] Y [ ] N

MEDICATIONS: It is important that you record below all medications you are taking

NAME OF MEDICATION	HOW MUCH / HOW OFTEN	FOR WHAT MEDICAL CONDITION?
Example: *Inderal*	*20 mg 3 times a day*	*High Blood Pressure*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

ALLERGIES: It is important that you record below all drug and other allergies

NAME OF MEDICATION	ADVERSE EFFECTS (HOW BAD IS THE REACTION)

CHECK HERE IF: You have no known drug allergies (NKDA) [ ] Latex allergy [ ]

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REVIEW OF SYSTEMS: Do you have trouble with or have you been diagnosed with any of the following?

Constitutional symptoms
- Fever [ ] Y [ ] N
- Weight loss [ ] Y [ ] N
- Fatigue [ ] Y [ ] N
- Cancer [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Ear, Nose, Mouth, Throat
- Hearing loss/ringing [ ] Y [ ] N
- Sinus problems [ ] Y [ ] N
- Chronic cough [ ] Y [ ] N
- Vertigo [ ] Y [ ] N
- Chronic ear infections [ ] Y [ ] N
- Dry Mouth [ ] Y [ ] N
- Laryngitis [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Neurological
- Multiple Sclerosis [ ] Y [ ] N
- Tumor [ ] Y [ ] N
- Stroke/CVA [ ] Y [ ] N
- Headaches [ ] Y [ ] N
- Migraines [ ] Y [ ] N
- Seizures/Epilepsy [ ] Y [ ] N
- Cerebral Palsy [ ] Y [ ] N
- Autism [ ] Y [ ] N
- IDD [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Psychiatric
- Depression [ ] Y [ ] N
- Attention deficit [ ] Y [ ] N
- Anxiety disorder [ ] Y [ ] N
- Difficulty sleeping [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Cardiovascular
- High blood pressure [ ] Y [ ] N
- Stroke/CVA [ ] Y [ ] N
- Heart Disease [ ] Y [ ] N
- Vascular disease [ ] Y [ ] N
- Murmur [ ] Y [ ] N
- Palpitation [ ] Y [ ] N
- Dizziness [ ] Y [ ] N
- Fainting Spells [ ] Y [ ] N
- Chest pain [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Respiratory
- Cigarette Smoker [ ] Y [ ] N
- Asthma [ ] Y [ ] N
- Bronchitis [ ] Y [ ] N
- Emphysema [ ] Y [ ] N
- Sleep Apnea [ ] Y [ ] N
- Wheezing [ ] Y [ ] N
- Chills [ ] Y [ ] N
- Shortness of breath [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Gastrointestinal
- Crohn's [ ] Y [ ] N
- Colitis [ ] Y [ ] N
- Ulcers [ ] Y [ ] N
- Heartburn/Reflux [ ] Y [ ] N
- Celiac disease [ ] Y [ ] N
- Nausea/Vomiting [ ] Y [ ] N
- Jaundice [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Genitourinary
- Kidney disease [ ] Y [ ] N
- Prostate disease/cancer [ ] Y [ ] N
- STD - herpetic/clamydia [ ] Y [ ] N
- Benign prostate hypertrophy [ ] Y [ ] N
- Pregnant/Nursing [ ] Y [ ] N
- Herpes [ ] Y [ ] N
- Chlamydia [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Musculoskeletal
- Osteoarthritis [ ] Y [ ] N
- Arthritis [ ] Y [ ] N
- Muscular dystrophy [ ] Y [ ] N
- Ankylosing spondylitis [ ] Y [ ] N
- Osteoporosis [ ] Y [ ] N
- Gout [ ] Y [ ] N
- Fibromyalgia [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Integumentary/skin
- Eczema [ ] Y [ ] N
- Rosacea [ ] Y [ ] N
- Psoriasis [ ] Y [ ] N
- Herpes Simplex/cold sores [ ] Y [ ] N
- Herpes Zoster/Shingles [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Endocrine
- Type 2 Diabetes Mellitus [ ] Y [ ] N
- Type 1 Diabetes Mellitus [ ] Y [ ] N
- Thyroid dysfunction [ ] Y [ ] N
- Hormonal dysfunction [ ] Y [ ] N
- Loss of Hair [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Hematologic/Lymphatic
- Anemia [ ] Y [ ] N
- Bleeding problems [ ] Y [ ] N
- Swelling/enlarged glands [ ] Y [ ] N
- High Cholesterol [ ] Y [ ] N
- Ulcer [ ] Y [ ] N
- Blood Loss (large volume) [ ] Y [ ] N

Allergic/Immunologic
- Drug allergies [ ] Y [ ] N
- Environmental allergies [ ] Y [ ] N
- Rheumatoid arthritis [ ] Y [ ] N
- Lupus [ ] Y [ ] N
- Sjogren's syndrome [ ] Y [ ] N
- Other _____ [ ] Y [ ] N

Other (please list) [ ] Y [ ] N

_____

PAST, FAMILY AND/OR SOCIAL HISTORY

Previous eye disease, eye illnesses, eye operations, eye injuries, eye treatments YOU have had [ ] Y [ ] N

PLEASE LIST HERE: _____

_____

Family history of EYE DISEASE (i.e. glaucoma, macular degeneration, lazy eye) [ ] Y [ ] N

Please list here what condition and which relative is affected: _____

_____

Family history of SYSTEMIC DISEASE (i.e. Diabetes, heart disease, high blood pressure, stroke, cancer) [ ] Y [ ] N

Please list here what condition and which relative is affected: _____

_____

Social History (Past and current activities, occupation, hobbies)

OCCUPATION: _____ HOBBIES: _____

ACTIVITIES: _____ VISUAL HOBBIES: _____

Do you use, or have you in the past, used any of the following products:

Tobacco [ ] Y [ ] N *If yes to any, please list how much/often:*

Alcohol [ ] Y [ ] N

Recreational drugs [ ] Y [ ] N _____