Southwest Plaza Vision Associates

Welcome! We appreciate you selecting our office for your eye care needs. We will do everything possible to insure your satisfaction.

NAME_____DATE_____DATE OF BIRTH_____AGE_____

GENDER_____PHONE_____SOC.SEC._____

ADDRESS_____CITY/STATE/ZIP_____

OCCUPATION_____EMPLOYER_____WORK PHONE_____

IF CHILD, PARENT'S NAME_____DATE OF LAST EXAMINATION_____

I PREFER TO BE CALLED_____EMAIL_____ DO

YOU WEAR GLASSES?_____CONTACT LENSES?_____HOW DID YOU LEARN ABOUT OUR OFFICE?_____ WHO

MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

ROUTINE CHECK UP _____ LOST OR BROKEN GLASSES _____ CONTACT LENS PROBLEMS _____
_____ LOST OR TORN CONTACT LENSES _____ FLASHES OF LIGHT _____
FLOATERS _____ DISTANCE VISION BLURRY _____ NEAR VISION BLURRY _____
HEADACHES _____ EYES ITCH, BURN, WATER _____ PERIPHERAL VISION PROBLEMS _____
OTHER_____

PLEASE TELL US ABOUT YOUR HEALTH HISTORY:	YOU (WHAT?)	MEDICATIONS:
CONSTITUTIONAL: Cancer, Fever, Weight Loss, Weight Gain, Fatigue, etc.		
EAR, NOSE, THROAT: Allergies, Sinus, Cough, Dry Mouth/Throat, etc.		
CARDIOVASCULAR: High Blood Pressure, Heart Surgery, Vascular Disease, etc.		
RESPIRATORY: Asthma, Bronchitis, Emphysema, COPD, etc.		
GENITAL, KIDNEY, BLADDER: Kidney Stones,etc.		
MUSCLES, BONES, JOINTS: Arthritis, Joint Pains, Head or Neck Injury, etc.		
SKIN:		
NEUROLOGICAL: Headaches, Migraines, Seizures, etc.		
PSYCHIATRIC: Depression, Anxiety, Insomnia, etc.		
ENDOCRINE: Thyroid, Diabetes, etc.		
BLOOD/LYMPH: Anemia, Cholesterol, Bleeding Problems, etc.		
ALLERGIC/IMMUNOLOGIC: Allergies, Rheumatic, HIV, Lupus, etc.		
GASTROINTESTINAL: Reflux, etc.		
OTHER:		
OCULAR: Injuries, Infections, Surgeries, Diseases, etc.		

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____IF YES, WHAT?_____

ARE YOU PREGNANT OR NURSING?_____

ANY HISTORY OF THE FOLLOWING IN ANY FAMILY MEMBER? (parents, grandparents, siblings, children)	YES (relationship)	ANY HISTORY OF THE FOLLOWING IN ANY FAMILY MEMBER? (parents, grandparents, siblings, children)	YES (relationship)
Poor Vision		Cancer	
Blindness		Diabetes	
Eye Turn (Strabismus)		High Blood Pressure	
Lazy Eye (Amblyopia)		Heart Disease	
Glaucoma		Thyroid Disease	
Cataracts		Other Inherited Diseases	
Macular Degeneration		If yes, what disease?	
Retinal Detachment			

Signed:_____Date: _____