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?

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WHAT BRINGS YOU TO OUR OFFICE TODAY?

ROUTINE CHECK UP ___________ LOST OR BROKEN GLASSES ___________ CONTACT LENS PROBLEMS __________
REDNESS OR PAIN ___________ 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:_____