# Welcome Back!

Date____/____/_____

Last Name_____ First Name_____ MI____ DOB:___/___/_____

M or F SSN:____/___/_____ Marital Status: Married / Single / Divorced / Widowed

**Height**:____ **Weight**____ **Race:** White, American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, Other Race, Decline **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline

Address: _____ City: _____ State:_____ Zip:_____

Home Ph:( )_____-_____ Work Ph:( )_____-_____ Ext: ____ Cell Ph:( )_____-_____

**E-mail Address:**_____ Spouse/Guardian Name: _____

Employer/School: _____ Occupation/ School Grade: _____

Sports/Hobbies:_____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail

Emergency Contact:_____Relation:_____ Phone #:( )_____-_____

**What are your visual symptoms today: Please circle any that apply, and indicate which eye(s):**

| | | | | | |
|---|---|---|---|---|---|
| [ ]Blurred Vision/Distance | R L B | [ ]Dry Eyes | R L B | [ ]Headaches | R L B |
| [ ]Blurred Vision/Near | R L B | [ ]Red Eyes | R L B | [ ]Migraine Headaches | R L B |
| [ ]Double Vision | R L B | [ ]Watery Eyes | R L B | [ ]Loss of Vision | R L B |
| [ ]Eye Strain | R L B | [ ]Wandering Eye | R L B | [ ]Crossed Eyes | R L B |
| [ ]Eye Infections | R L B | [ ]Mucus Discharge | R L B | [ ]Light Sensitive | R L B |
| [ ]Eye Pain/Soreness | R L B | [ ]Floaters or Spots | R L B | [ ]Gritty Feeling | R L B |
| [ ]Tired Eyes | R L B | [ ]See Flashes | R L B | [ ]Poor Color Vision | R L B |
| [ ]Burning Eyes | R L B | [ ]See Halos | R L B | [ ]Droopy Lid | R L B |
| [ ]Itchy Eyes | R L B | [ ]Poor Night Vision | R L B | | |

**Please List anything in YOUR MEDICAL HISTORY not listed on your previous form.**

| | | |
|---|---|---|
| Cardiovascular: __None<br>__Stroke __Heart Disease<br>__Hypertension __Other | Endocrine: __None<br>__Diabetes __Thyroid<br>__Diabetes Suspect __Other | Respiratory: __None<br>__Asthma __COPD<br>__Bronchitis __Other |
| Genitourinary: __None<br>__Pregnancy __STDs<br>__Prostate Disorder __Other | Ocular: __None<br>__Glaucoma __Detached Retina<br>__ARMD __Other | Psychiatric: __None<br>__ADHD __Schizophrenia<br>__Depression __Other |
| Neurological: __None<br>__Epilepsy __MS<br>__MD __Other | Musculoskeletal: __None<br>__Arthritis __Fibromyalgia<br>__Osteoporosis __Other | Immunologic: __None<br>__AIDS __Lupus<br>__RA __Other |
| Hematological: __None<br>__Anemia __Leukemia<br>__Cancer __Other | Gastrointestinal: __None<br>__Crohn's __Acid Reflux<br>__Colitis __Other | Ear/Nose/Throat: __None<br>__Hearing Loss __Sinusitis<br>__Trauma __Other |
| Dermatologic: __None<br>__Eczema __Rosacea<br>__Psoriasis __Other | Allergies to: __None<br>Drug_____<br>Environmental_____ | Alcohol Use: Yes / No<br><br>Tobacco Use: Yes / No |

**Please List ALL MEDICATIONS you take**: _____

_____

**Have you had any eye related injuries, diseases or surgery since your last visit?** ___Yes ____No