Welcome to the office of ***Joseph & Bass Eye Associates, P.A***

Date: ____/____/____

Name: _____ DOB:___/___/____ SSN:_____Occupation:_____
Last First MI Last 4

Address:_____City:_____ State:_____Zip:_____

e-mail:_____ Ph:_____-_____-_____ How did you hear about us?:_____
□Home □ Work □ Cell

Marital Status: □Single □Married □Other Sponsors name:_____ Benefits #:_____
Relation to patient: □ Self □Parent □Spouse

Review of Systems: Have you ever had or now have any of the following? **Please ☑ condition.**

Constitution □Yes □No
- □ Cancer
- □ Fatigue Syndrome
- □ Other: _____

Ear/ Nose/Throat problems □Yes □No
- □ Hearing loss
- □ Sinusitis
- □ Dry Mouth
- □ Other: _____

Neurological □Yes □No
- □ Multiple Sclerosis
- □ Epilepsy
- □ Tumor
- □ Stroke/CVA
- □ Migraine
- □ Other: _____

Respiratory □Yes □No
- □ Asthma
- □ Bronchitis
- □ Emphysema
- □ Chronic Obstruction
- □ Sleep Apnea
- □ Other: _____

Cardiovascular: □Yes □No
- □ High blood pressure
- □ Stroke/CVA
- □ Heart Disease
- □ Vascular Disease
- □ Congestive Heart Failure
- □ Other:_____

Psychiatric □Yes □No
- □ Depression
- □ ADD/ADHD
- □ Other: _____

Gastrointestinal □Yes □No
- □ Ulcer
- □ Acid reflux
- □ Other: _____

Genitourinary □Yes □No
- □ Kidney Disease
- □ Prostate Cancer
- □ STD: _____
- □ Other: _____

Musculoskeletal □Yes □No
- □ Arthritis
- □ Osteoarthritis
- □ Fibromyalgia
- □ Muscular Dystrophy
- □ Osteoporosis
- □ Other: _____

Integumentary □Yes □No
- □ Eczema
- □ Cold Sores
- □ Shingles
- □ Other: _____

Endocrine □Yes □No
- □ Diabetes
- □ Thyroid
- □ Other: _____

Lymphatic □Yes □No
- □ Anemia
- □ Ulcer
- □ Other:_____

Allergic/Immunologic □Yes □No
□ Allergies □ Lupus □ Rheumatoid Arthritis □ Other: _____

Current Medications: _____

Are you Allergic to any Medications? □Yes □No: _____

- **Do you use tobacco products? □Yes □No**

Amt: _____

□ Cigars □ Cigarettes □ Pipe □ Other

□ Every day smoker □ Former smoker □ Never Smoker

- **Do you drink Alcohol beverages? □Yes □No**

Amt: _____

- **Are you pregnant or nursing? □Yes □No □N/A**

- **Do you work or play on computers?** □Yes □No (2-4-6-8-10 Hours)

Do you drive? □Yes □ No
Do you have difficulty seeing to drive at night? □Yes □No
Are you bothered by the glare of lights when you drive? □Yes □No
Do you feel that your eyes are very sensitive to sunlight? □Yes □No

Family History:			Father	Mother	Siblings	Grandparents
Retinal Detachment	Yes	No	□	□	□	□
Macular Degeneration	Yes	No	□	□	□	□
Cataracts	Yes	No	□	□	□	□
Glaucoma	Yes	No	□	□	□	□
Diabetes	Yes	No	□	□	□	□
Cancer	Yes	No	□	□	□	□
High Blood Pressure	Yes	No	□	□	□	□
Thyroid Disease	Yes	No	□	□	□	□
Other:_____	Yes	No	□	□	□	□

Are you diabetic? □ Yes □No Year of diagnosis? _____ Type? _____
Last fasting sugar number? _____ Last hemoglobin A1C test no? _____

Have you ever had an eye surgery or injury? □Yes □No _____

Have you been diagnosed with an eye disease or condition? □Yes □No _____

Date of last eye exam: _____ **Do you wear glasses?** □Yes □No **How old are your glasses? _____**

Do you wear contacts? □Yes □No **What brand**? _____ **How old are your contact lenses? _____**

Do you have any of the following eye related problems? (Please check all that apply)

___Blurred vision
___Eye pain
___Double vision
___Dry eyes
___Mucous discharge
___ Glare
___Excessive redness
___Burning
__Gritty feeling
___Excessive Tearing
___Itching
___Floating spots
___Chronic infection
___Loss of vision
___Flashes of light