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® American Optometric Association

Doctors of Optometry

Date					
MrMrsMiss	Ms	Dr			
Name: First		MII	.ast		
Address		City		State	Zip
Home Ph#()	Wo	rk#()	····	Cell#()	
Email Address	Linvin .		·····		
*How should we contact you?	НОМЕ	WORK	CELL	TEXT EMAIL	
Social Security #		Date of Birth	- 	Marital St	atus
Occupation	upationEmployer/School				
Vision Insurance		Me	edical Ins	surance	
Date of last eye exam			Dilated?_		
Do you wear glasses? YES/NO)	Do yo	u wear c	ontacts? YES/NO	
Who may we thank for referrin	g you?			<u></u>	
Are you interested in information on Laser Vision Correction?					

Date:	Date Of Last Eye Exam:			
Patient:	Birthdate:			
Address:	Age:			
Referred By:	Sex:			
	ncy Contact Telephone:			
REVIEW OF HEALTH SYSTEMS ♦ (ROS)				
◆EYES Have you had or do you have any of the following?	5) 5) 5) 5 (ROS)			
Glaucoma: State Control Cont				
Cataracts:				
Dry Eyes: Sign Sign Sign Sign Sign Sign Sign Sign				
Other eye problems:	TO THE CONTRACT OF THE CONTRAC			
Other eye problems.				
Please describe any problems with the following health systems:				
◆GASTROINTESTINAL □ No Problem	♦ NEUROLOGICAL □ No Problem			
□ Ulcer □ Colitis □ Heartburn □ Diarrhea	☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness			
□ Other: Meds:	☐ Other: Meds:			
◆ EARS/NOSE/THROAT □ No Problem	◆ CONSTITUTIONAL □ No Problem			
□ Upper Respiratory Infection □ Sinusitis □ Chronic colds	☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability			
□ Other:	☐ Trauma ☐ Other:			
Meds: ◆ CARDIOVASCULAR □ No Problem	□ Meds: MUSCULOSKELETAL □ No Problem			
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Stroke	Muscular Dystrophy Osteoarthritis Joint Pain Muscle Aches			
☐ High Cholesterol ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:	☐ Other:			
Meds:	Meds:			
◆ RESPIRATORY □ No Problem	♦ INTEGUMENTARY (SKIN) □ No Problem			
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing ☐ Other:	☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer ☐ Excessive Dryness ☐ Other:			
Meds:	Meds:			
◆ ALLERGIC/IMMUNE □ No Problem	◆ ENDOCRINE (GLANDS) □ No Problem			
☐ Allergies: ☐ Rheumatoid Arthritis	☐ Thyroid Dysfunction ☐ Hormonal Dysfunction			
☐ Drug allergies: ☐ Lupus ☐ HIV ☐ Meds:	☐ Type 1 Diabetes ☐ Type 2 Diabetes Meds:			
LI Meds.				
◆ BLOOD / LYMPH □ No Problem ◆ PSYCHIATRIC (ME	NTAL □ No Problem □ ◆ GENITOURINARY □ No Problem			
◆ BLOOD / LYMPH □ No Problem ◆ PSYCHIATRIC (ME □ Anemia □ Leukemia □ Depression □ Bipolar	NTAL) □ No Problem			
☐ Anemia ☐ Leukemia ☐ Depression ☐ Bipolar ☐ Other: ☐ Other:	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
☐ Anemia ☐ Leukemia ☐ Depression ☐ Bipolar ☐ Other: Meds: ☐ Meds: ☐ Depression ☐ Bipolar ☐ Other: Meds: ☐ Meds: ☐ Depression ☐ Bipolar ☐ Other:	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds:			
□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: □ Other: Meds: PAST, FAMILY, & SOCIA	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds:			
□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? □Yes □No Date: Typo	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
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□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? Have you had an eye injury? Have you had a retinal detachment? □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA * Typolar □ Other: Meds: ** **PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolar □ Other: Meds: ** ** ** ** ** ** ** ** **	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? Have you had an eye injury? Have you had a retinal detachment? Name of family doctor: □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA ** **PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolate: □ Typolate: □ Typolate: □ Other: Meds: ** ** **PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolate: □ Typolate: □ Other: Meds: ** ** ** ** ** ** ** ** **	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □Yes □No Date: □ Typolar Have you had an eye injury? □Yes □No Date: □ Typolar Name of family doctor: List any eye medications you are currently taking:	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? Have you had an eye injury? Have you had a retinal detachment? Name of family doctor: □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA ** **PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolate: □ Typolate: □ Typolate: □ Other: Meds: ** ** **PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolate: □ Typolate: □ Other: Meds: ** ** ** ** ** ** ** ** **	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Depression □ Bipolar □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Typolar Have you had an eye injury? □ Yes □ No Date: □ Typolar Name of family doctor: List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □ Yes □ No Amount: □ Yes □ No Yes	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
□ Anemia □ Leukemia □ Depression □ Dipolar □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □Yes □No Date: □ Typolar Have you had a retinal detachment? □Yes □No Date: □ Typolar Name of family doctor: □ Typolar List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □Yes □No Amount: □ Oyou use other substances? □Yes □No What: □ Oyou use Oyou use other substances? □Yes □No What: □ Oyou use Oyou use other substances? □Yes □No What: □ Oyou use Oyou us	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other:			
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□ Anemia □ Leukemia □ Depression □ Depression □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? □Yes □No Date: □ Type Have you had a retinal detachment? □Yes □No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: * SOCIAL HISTORY Do you use alcohol? □Yes □No Amount: □ Do you use tobacco? □Yes □No Amount: □ Do you use other substances? □Yes □No What: □ Describe any special visual needs: * FAMILY HISTORY □ Do any family members have any of the follow High blood pressure □Yes □No Relation □ Other: □ Other	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: L HISTORY ★ (PFSH)			
□ Anemia □ Leukemia □ Depression □ Depression □ Other: Meds: PAST, FAMILY, & SOCIA * PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Type Have you had a retinal detachment? □ Yes □ No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: * SOCIAL HISTORY Do you use alcohol? □ Yes □ No Amount: □ Do you use other substances? □ Yes □ No What: □ Describe any special visual needs: * FAMILY HISTORY Do any family members have any of the follow Poliabetes □ Yes □ No Relation □ Diabetes □ Diabetes □ Diabetes □ Diabetes □ Di	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: IL HISTORY ★ (PFSH) B: □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: IL HISTORY ★ (PFSH)			
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□ Anemia □ Leukemia □ Depression □ Dibploar □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Type Have you had an eye injury? □ Yes □ No Date: □ Type Have you had a retinal detachment? □ Yes □ No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □ Yes □ No Amount: □ Do you use other substances? □ Yes □ No What: □ Describe any special visual needs: ★ FAMILY HISTORY Do any family members have any of the follow High blood pressure □ Yes □ No Relation □ Glaucoma □ Yes □ No Relation □ Selection □ Yes □ No Relation □ Selection □ Yes □ No Relation □ Yes □ No Relation □ Selection □ Yes □ No Relation □ Yes	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: L HISTORY ★ (PFSH) atment: Macular Degeneration □ Yes □ No Relation Retinal Detachment □ Yes □ No Relation Cataracts □ Yes □ No Relation			
□ Anemia □ Leukemia □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □Yes □No Date: □Yes Have you had a retinal detachment? □Yes □No Date: □ Type Have you had a retinal detachment? □Yes □No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □Yes □No Amount: □ Do you use other substances? □Yes □No Amount: □ Describe any special visual needs: ★ FAMILY HISTORY Do any family members have any of the follow High blood pressure □Yes □No Relation □Yes □No Rela	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: L HISTORY ★ (PFSH) a: atment: Macular Degeneration □ Yes □ No Relation Retinal Detachment □ Yes □ No Relation Cataracts □ Yes □ No Relation Relation □ Yes □ No Relation			
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□ Anemia □ Leukemia □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Type Have you had a retinal detachment? □ Yes □ No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □ Yes □ No Amount: □ Do you use other substances? □ Yes □ No What: □ Describe any special visual needs: ★ FAMILY HISTORY Do any family members have any of the follow Relation □ Diabetes □ Yes □ No Relation □ Description Other eye condition □ Yes □ No Relation □ Description Patient Signature: □ Description	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: L HISTORY ★ (PFSH) S: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □			
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□ Anemia □ Leukemia □ Other: Meds: PAST, FAMILY, & SOCIA ★ PATIENT PAST HISTORY Have you had any eye operations? □ Yes □ No Date: □ Type Have you had a retinal detachment? □ Yes □ No Date: □ Tree Name of family doctor: List any eye medications you are currently taking: ★ SOCIAL HISTORY Do you use alcohol? □ Yes □ No Amount: □ Do you use other substances? □ Yes □ No What: □ Describe any special visual needs: ★ FAMILY HISTORY Do any family members have any of the follow Relation □ Diabetes □ Yes □ No Relation □ Description Other eye condition □ Yes □ No Relation □ Description Patient Signature: □ Description	□ ADD/ADHD □ STD □ Bladder Infection □ Blood in Urine □ Other: Meds: L HISTORY ★ (PFSH) Ing problems: □			
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