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Doctors of Optometry

Date_____

Mr._____Mrs._____Miss_____Ms_____Dr._____

Name: First_____MI____Last_____

Address_____City_____State_____Zip_____

Home Ph#(____)_____Work#(____)_____Cell#(____)_____

Email Address_____

*How should we contact you? HOME WORK CELL TEXT EMAIL

Social Security #_____Date of Birth_____Marital Status_____

Occupation_____Employer/School_____

Vision Insurance_____Medical Insurance_____

Date of last eye exam_____Dilated?_____

Do you wear glasses? YES/NO Do you wear contacts? YES/NO

Who may we thank for referring you?_____

Are you interested in information on Laser Vision Correction?_____

Date: Date Of Last Eye Exam:
Patient: Birthdate:
Address: Age:
Referred By: Sex:
Emergency Contact: Emergency Contact Telephone:

REVIEW OF HEALTH SYSTEMS ◆ (ROS)

◆EYES Have you had or do you have any of the following?

Glaucoma:	☐Yes ☐No	Explain:
Cataracts:	☐Yes ☐No	Explain:
Dry Eyes:	☐Yes ☐No	Explain:
Other eye problems:	☐Yes ☐No	Description:

Please describe any problems with the following health systems:

◆GASTROINTESTINAL ☐ No Problem
☐ Ulcer ☐ Colitis ☐ Heartburn ☐ Diarrhea
☐ Other:
Meds:

◆ NEUROLOGICAL ☐ No Problem
☐ Epilepsy ☐ Multiple Sclerosis ☐ Headaches ☐ Numbness
☐ Other:
Meds:

◆ EARS/NOSE/THROAT ☐ No Problem
☐ Upper Respiratory Infection ☐ Sinusitis ☐ Chronic colds
☐ Other:
Meds:

◆ CONSTITUTIONAL ☐ No Problem
☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Developmental Disability
☐ Trauma ☐ Other:
☐ Meds:

◆ CARDIOVASCULAR ☐ No Problem
☐ High Blood Pressure ☐ Heart Disease ☐ Vascular Disease ☐ Stroke
☐ High Cholesterol ☐ Chest Pain ☐ Irregular Heart Beat ☐ Other:
Meds:

◆ MUSCULOSKELETAL ☐ No Problem
☐ Muscular Dystrophy ☐ Osteoarthritis ☐ Joint Pain ☐ Muscle Aches
☐ Other:
Meds:

◆ RESPIRATORY ☐ No Problem
☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Wheezing ☐ Coughing
☐ Other:
Meds:

◆ INTEGUMENTARY (SKIN) ☐ No Problem
☐ Psoriasis ☐ Eczema ☐ Rashes ☐ Acne ☐ Cancer
☐ Excessive Dryness ☐ Other:
Meds:

◆ ALLERGIC/IMMUNE ☐ No Problem
☐ Allergies:_____ ☐ Rheumatoid Arthritis
☐ Drug allergies:_____ ☐ Lupus ☐ HIV
☐ Meds:

◆ ENDOCRINE (GLANDS) ☐ No Problem
☐ Thyroid Dysfunction ☐ Hormonal Dysfunction
☐ Type 1 Diabetes ☐ Type 2 Diabetes
Meds:

◆ BLOOD / LYMPH ☐ No Problem
☐ Anemia ☐ Leukemia
☐ Other:
Meds:

◆ PSYCHIATRIC (MENTAL) ☐ No Problem
☐ Depression ☐ Bipolar ☐ ADD/ADHD
☐ Other:
Meds:

◆ GENITOURINARY ☐ No Problem
☐ STD ☐ Bladder Infection ☐ Blood in Urine
☐ Other:
Meds:

PAST, FAMILY, & SOCIAL HISTORY ★ (PFSH)

★ 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:_____ Treatment:_____
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 following problems:

High blood pressure ☐Yes ☐No Relation _____
Diabetes ☐Yes ☐No Relation _____
Glaucoma ☐Yes ☐No Relation _____
Other eye condition ☐Yes ☐No Relation _____ Description:_____

Macular Degeneration ☐Yes ☐No Relation _____
Retinal Detachment ☐Yes ☐No Relation _____
Cataracts ☐Yes ☐No Relation _____

Patient Signature: _____

Date Reviewed / Changes

_____ ☐ No Changes _____
_____ ☐ No Changes _____
_____ ☐ No Changes _____
_____ ☐ No Changes _____

FOR OFFICE USE ONLY

◆ROS ELEMENTS ☐ PP=1 ☐ Ext=2-9 ☐ Comp= 10-14
★ PFSH AREAS ☐ 1 ☐ 2 ☐ 3

Dr. Init	Review Date	ROS Elements	PFSH Areas