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Please complete this form to the best of your knowledge and bring it with you to your appointment.

A. GENERAL PATIENT INFORMATION

Full Name _____ Social Security Number _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____
 Date of Birth _____ Marital Status: Single Married Divorced Separated Widowed
 Employer _____ Occupation _____
 Business address _____ City _____ State _____ Zip _____
 Business Phone _____
 Spouse Employer _____ Occupation _____
 Nearest living relative _____ Phone _____

Major Medical Insurance Company _____
 Policy Number _____
 Who may we thank for referring you to our office? _____

B. MEDICAL HISTORY

Most recent medical examination: _____
 Doctor's Name _____ Date _____

Results

Current diet – Nutritionally: Excellent Good Fair Poor

Personal & Family Medical History

Allergies	<input type="radio"/> Self <input type="radio"/> Family	Glaucoma	<input type="radio"/> Self <input type="radio"/> Family
Asthma	<input type="radio"/> Self <input type="radio"/> Family	Eye disease	<input type="radio"/> Self <input type="radio"/> Family
Arthritis	<input type="radio"/> Self <input type="radio"/> Family	Heart disease	<input type="radio"/> Self <input type="radio"/> Family
High Blood Pres	<input type="radio"/> Self <input type="radio"/> Family	Eye injury	<input type="radio"/> Self <input type="radio"/> Family
Eye surgery	<input type="radio"/> Self <input type="radio"/> Family	Cancer	<input type="radio"/> Self <input type="radio"/> Family
Diabetes	<input type="radio"/> Self <input type="radio"/> Family	Cataract	<input type="radio"/> Self <input type="radio"/> Family
Thyroid Condition	<input type="radio"/> Self <input type="radio"/> Family	Blindness	<input type="radio"/> Self <input type="radio"/> Family
_____	<input type="radio"/> Self <input type="radio"/> Family	_____	<input type="radio"/> Self <input type="radio"/> Family

Current Medications (Rx & Over the Counter)

Name of Medications

Antihistamines No Yes _____
 Diuretics (water pills) No Yes _____
 Blood Pressure Pills No Yes _____
 Oral contraceptives No Yes _____
 Sleeping tablets No Yes _____
 Eye drops No Yes _____
 Other _____

Are you currently under the care of a physician? No Yes

Name of physician _____

C. VISUAL HISTORY

Previous examinations: _____
Doctor's Name _____ Date _____

Reason for examination: _____

Results: _____

Do you wear glasses? No Yes

How often do you wear them? _____ How long have you had them? _____

Members of the family who have had visual attention and why:

<u>NAME</u>	<u>AGE</u>	<u>VISUAL SITUATION</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. PRESENT SITUATION

Describe any indications of visual difficulty: _____

Do you feel your vision hinders your daily activities in any way? If so, how? _____

Please mark any of the following that apply:

- Eyes itch, burn, tear, red at distance or near.
- Periodic or constant double vision at near or distance
- Omission of words when reading or copying material
- Covering or closing one eye
- Skipping lines when reading
- Repetition of letters in words; difficulty aligning columns of numbers
- Headaches or nausea with near tasks
- Lack of comprehension when reading
- Short attention span when performing visual tasks
- Letters, words, or both appear to float around
- Excessive head movement when reading
- Frequent loss or copying material
- Confusion of what is being seen or read
- Close working distance at near
- Use finger or marker to keep place when reading
- Head tilt
- Postural changes when doing desk work
- General or visual fatigue at end of the day
- Difficulty sustaining near point work such as reading or writing
- Blur at distance or near after reading

Comments on any above checked items: _____

E. EMPLOYMENT OR SCHOOL

Current position _____ Major Course of Study _____

How many hours daily do you spend:

At a desk? _____ Reading or studying? _____ Working at near distances? _____

Are you achieving to your potential in work or school? No Yes

Do you feel you are getting adequate return for the amount of effort you put into a task? _____

Does your work or course of study demand comprehension? No Yes

F. AVOCATIONS

Describe what activities comprise the majority of your spare time. _____

Do you watch T.V.? No Yes How long per day and days per week? _____

Viewing distance _____

Are you seriously involved in athletics? No Yes

Do you feel you are achieving up to your potential? No Yes

Out of all the sports you have played:

List the ones you excel in _____

List the ones you do poorly in _____

Thank you for completing this form.

The information supplied will permit us to make a complete optometric evaluation of your visual system related to your specific needs.