

Steven Sage Hider, OD, Quyen T. Immoos, OD, Lauren R. Tackett, OD, Valerie Suey, OD

**Name: Mr./Mrs./Ms./Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Preferred Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SSN#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mailing Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation/Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Phone(H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnicity:** Hispanic/Latino **OR**

**Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Non-Hispanic/Non-Latino

**Preferred Form of Contact (CIRCLE ONE):**

**\*TEXT \*PHONE CALL HOME \*PHONE CALL CELL \*EMAIL**

**To better serve you, please circle all that apply:**

Sex Assigned at Birth: Male Female Decline to State

Current Gender: Male Female Transgender Male/FTM Transgender Woman/MTF

Preferred Pronouns: He/Him/His She/Her/Hers They/Them/Their Other: \_\_\_\_\_\_\_\_\_\_\_

**Primary Care Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date & Reason for last PCP apt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Last Eye Dr. & exam (if not here): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Personal Medical History**

**Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**List all medications including oral contraceptives, aspirin, OTC medications, vitamins and herbal supplements (and dose if known):**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any allergies to metals? **YES NO** (List allergy and reaction)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have any allergies to medications? **YES NO**  (List allergy and reaction)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all major surgeries you have had with approximate date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you pregnant/ nursing**? **YES NO** (If yes, circle which one) If pregnant, list due date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diabetics:** Date of diagnosis (month/year) \_\_\_\_\_\_\_\_\_\_\_\_ Last HbA1c (%) \_\_\_\_\_\_\_\_\_\_/ Date Taken \_\_\_\_\_\_\_\_

If self-monitored, list last measurement/ approximate date taken: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear glasses? **YES NO** How old are your glasses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear contact lenses?  **YES NO**  How old is your current pair of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work on the computer? **YES NO** Approximate hours per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal & Family Medical History**

Please note any personal and family history (parents, grandparents, siblings, children: living or deceased) for the following:

List Self/Relatives Having the Condition

Glaucoma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Macular Degeneration \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Retinal Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_

Eye Injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amblyopia (lazy eye) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Strabismus (eye turn) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other Major Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cancer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**

Do you use tobacco products?  **YES NO** Type/ Amount/ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If tobacco non-user: Former smoker/ Never smoker (circle one)

Do you drink alcohol?  **YES NO** Type/ Amount/ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use illegal drugs?  **YES NO** Type/ Amount/ How long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the box if you currently have, or have had *significant* problems in the following areas:**

**Eyes**

* Blurred vision
* Distorted vision
* Halos
* Loss of vision
* Loss of peripheral
* Double vision
* Dryness
* Discharge
* Redness
* Sandy/gritty feeling
* Itching
* Burning
* Excess tearing/ watering
* Glare/ Light sensitivity
* Eye pain
* Flashing lights
* Floaters
* Chronic infections
* Tired eyes

**Constitution**

* Fever
* Weight loss/gain

**Cardiovascular**

* High blood pressure
* Cholesterol
* Angina
* Coronary artery disease
* Congestive heart failure
* Bypass graft

**Ear, Nose, Mouth, Throat**

* Sinus congestion
* Chronic sinusitis
* Runny nose
* Postnasal drip
* Chronic cough
* Dry throat/ mouth
* Hearing loss
* Ringing in ears/ Tinnitus
* Vertigo

**Respiratory**

* Asthma
* Chronic bronchitis
* COPD
* Emphysema
* Sarcoid
* Tuberculosis

**Stomach/ Intestinal**

* Diarrhea
* Constipation
* Gastric reflux
* Crohn’s Disease
* Ulcerative Colitis
* Hepatitis

**Genitourinary**

* Genital/ Kidney/ Bladder

**Muscles/ Bones/ Joints**

* Arthritis
* Rheumatoid arthritis
* Osteoporosis

**Psychiatric**

* Depression
* Anxiety

**Skin Conditions**

* Eczema
* Psoriasis
* Dermatitis
* Skin cancer

**Neurological**

* Chronic headaches
* Migraines
* Seizures
* Multiple sclerosis
* Stroke
* TIA

**Endocrine**

* Diabetes Type 1
* Diabetes Type 2
* Prediabetes
* Thyroid disorder

**Lymphatic/ Blood**

* Anemia
* Systemic Lupus (SLE)
* Lyme Disease
* Other blood disorder

**Allergies/ Immunologic**

* Allergies/ Hay fever
* Autoimmune disorder
* HIV/AIDS

**Cancer**

* Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered YES to any of the above or have a condition not listed above, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I hereby certify that the above statements are true and correct to the best of my knowledge.**