ALLISONVILLE EYE CARE CENTER

Name______________________________________ DOB_____/_____/_____ Date_____/_____/_____

Primary Care Physician:
Name ___________________________
Address ___________________________
____
Phone ___________________________

Other Specialist/Physician:
Name ___________________________
Address ___________________________
____
Phone ___________________________

When was your last eye exam? ________________

Referred by: ___________________________

YES **NO**

____ ____ Do you wear glasses? Please circle: Distance / Computer / Near / Full-time / Part-time
____ ____ Do you wear contact lenses? Yes / No ______# days per week / Brand______________________

Please list any prescription or non-prescription medications you are taking:
____
____

Please list any prescription or non-prescription eye drops you are using:
____

YOUR OCULAR HISTORY- *Please give details on any YES answer.*

YES **NO**

____ ____ History of Eye Injury or Eye Infection ____
____ ____ History of Eye Disease____
____ ____ History of a Crossed or Out-turned Eye____
____ ____ History of Eye Surgery (Give dates if possible)_______________________________________
____ ____ Do you have a family history of Glaucoma or Macular Degeneration?
____
____ ____ Do you smoke? ______# packs per day
____ ____ Do you drink alcohol? ______# of drinks per day/week
____ ____ Do you have any communicable disease? ____
____ ____ If female, are you pregnant or nursing? Due Date_________________________________
____

PERSONAL MEDICAL HISTORY- *Please indicate whether there is a history of problems in each category.*

YES **NO** **(NOT FAMILY HISTORY)**

____ ____ Cancer ____
____ ____ Allergies (Seasonal / Year-round / Medications) ____________________________________
____ ____ Cardiovascular (High Blood Pressure / Heart Disease / Circulation Problem / Stroke)
____
____ ____ Constitutional difficulties (general feeling of wellness)______________________________
____ ____ Diabetes (Yr./Yrs. Diagnosed________) / Increased Cholesterol / Gout / Low Thyroid / Hyperthyroid
____
____ ____ Gastrointestinal /Stomach____
____ ____ Genitourinary ____
____ ____ Head (Ear / Nose / Throat Disorder / Headaches / Migraines / Sinus Problems)
____
____ ____ Blood Disease / Lymphatic____
____ ____ Immunologic ____
____ ____ Skin____
____ ____ Musculoskeletal (Arthritis) ____
____ ____ Neurological ____
____ ____ Psychiatric / Depression____
____ ____ Respiratory____
____ ____ Other____