TOTAL EYECARE

Robert A. Colon, OD Kurt G. Alleman, OD Colby B. Curtis, OD

Name: _____ Date: _____ Optos Retinal Scan: Yes / No
Main Reason for Today's Visit: _____
Name of Current Medical Physician: _____
What hobbies do you enjoy: _____

- **Do you wear contact lenses**: *Yes / No* **If yes:** what solutions do you use:_____
- **Are you interested in Contact lenses**: *Yes / No*
- **Do you wear glasses?** *Yes / No*
- **Do you have a second pair/ back up pair of glasses?** *Yes / No*
- **Do you do a lot of close-up work?** *Yes / No*
- **Do you work at the computer for extended periods of time?** *Yes / No*
- **Do you have a pair of sunglasses?** *Yes / No* Prescription / Non- prescription
- **Are you having any problems with your current eyewear?** (please explain)

_____

Please explain any vision troubles you are having With your current GLASSES/CONTACTS:

Difficulty reading?	Yes / No
Blurry distance vision?	Yes / No
Trouble seeing at night?	Yes / No
Trouble seeing computer?	Yes / No
Double vision?	Yes / No
Floaters or spots in vision?	Yes / No
Flashes of light in vision?	Yes / No

Other? _____

Please explain any eye symptoms you are having:

Glare or reflections?	Yes / No
Eye strain or fatigue?	Yes / No
Red eyes?	Yes / No
Dry, gritty, or sandy feeling?	Yes / No
Burning sensation?	Yes / No
Itchy eyes?	Yes / No
Watery or teary eyes?	Yes / No
Sore eyes?	Yes / No
Sensitive to light?	Yes / No

Other? _____

Are you currently experiencing:

Headaches?	Yes / No
Dizziness?	Yes / No
Fainting?	Yes / No
Nausea?	Yes / No

For our female patients:

Are you currently pregnant?	Yes / No
Breastfeeding?	Yes / No

Please explain any PERSONAL medical history:

Diabetes?	Yes / No
High blood pressure?	Yes / No
High cholesterol?	Yes / No
Asthma?	Yes / No
Heart disease?	Yes / No
Cancer?	Yes / No
Arthritis?	Yes / No
Thyroid disease?	Yes / No
Surgeries?	Yes / No

If yes, what kind? _____
Other? _____

Please explain any PERSONAL eye history:

Cataracts?	Yes / No
Glaucoma?	Yes / No
Macular degeneration?	Yes / No
Trauma?	Yes / No
Lazy eye?	Yes / No

Other? _____

Previous eye surgeries:

Cataract?	Yes / No
LASIK?	Yes / No
Eye muscle?	Yes / No
Retinal detachment?	Yes / No
Injections?	Yes / No

Other?_____

Do you smoke tobacco?	Yes / No
Smokeless tobacco?	Yes / No

Please explain any FAMILY medical history:
Diabetes *Yes / No* Relationship: _____ **Heart Disease** *Yes / No* Relationship: _____
Blindness *Yes / No* Relationship: _____ **Cataracts** *Yes / No* Relationship: _____
Glaucoma *Yes / No* Relationship:_____ **Macular Degeneration** *Yes / No* Relationship: _____
Please list any allergies you have, including allergies to any medications:

_____

Please list any medications you are currently taking.

_____

_____

_____

Please list any eye medications including over-the-counter eye drops:

_____