Total Eyecare

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Name: _____ DOB: _____ Date: _____

Main reason for today's visit: _____

Current medical physician: _____

What hobbies do you enjoy? _____

Optomap Image? Yes / No

- Do you wear contact lenses? Yes / No If yes, which brand? _____ Solution? _____
- Are you interested in contact lenses? Yes / No If yes, have you worn them before? Yes / No
- Do you wear glasses? Yes / No Are you having any problems with your current eyewear? Yes / No
  If yes, please explain: _____

ARE YOU HAVING ANY OF THESE PROBLEMS WITH WITH YOUR CURRENT VISION?

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

Other? _____

ARE YOU HAVING ANY OF THE FOLLOWING SYMPTOMS?

Glare or reflections on lights?	Yes / No
Red eyes?	Yes / No
Dry, gritty, or sandy feeling?	Yes / No
Burning?	Yes / No
Itching?	Yes / No
Watering/tearing?	Yes / No
Sensitivity to light?	Yes / No
Headaches?	Yes / No

SOCIAL HISTORY

Do you smoke tobacco?	Yes / No
Do you use smokeless tobacco?	Yes / No

FAMILY HISTORY

Diabetes?	Yes / No
Glaucoma?	Yes / No
Macular Degeneration?	Yes / No
Other eye disease?	Yes / No

If so, what kind? _____

FEMALE PATIENTS

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

YOUR PERSONAL MEDICAL HISTORY

Diabetes?	Yes / No
High blood pressure?	Yes / No
High cholesterol?	Yes / No
Heart disease?	Yes / No
Asthma?	Yes / No
COPD?	Yes / No
Cancer?	Yes / No

If yes, what type? _____

Thyroid disease?	Yes / No
Arthritis?	Yes / No

Other? _____

List any major surgeries _____

_____

YOUR PERSONAL EYE HISTORY

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

Other? _____

PREVIOUS EYE SURGERIES

Cataracts?	Yes / No
LASIK/PRK/ICL?	Yes / No
Eye muscle?	Yes / No
Retinal detachment?	Yes / No
Injections?	Yes / No

Other? _____

MEDICATIONS AND ALLERGIES

List any allergies, including allergies to medications:

_____

_____

List any medications/supplements you are currently taking: _____

_____

_____

List any eye medications including over-the-counter eye drops: _____