

# PINNACLE EYE GROUP

## General Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ M \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 M or F \_\_\_\_\_ SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Marital Status: Married / Single / Divorced / Widowed  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Ph: ( ) \_\_\_\_\_ Work Ph: ( ) \_\_\_\_\_ Cell Ph: ( ) \_\_\_\_\_  
 Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Sports/Hobbies: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: ( ) \_\_\_\_\_

### CASE HISTORY / REASON FOR VISIT:

Mother's Name: \_\_\_\_\_ SSN : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address if different: \_\_\_\_\_

Father's Name: \_\_\_\_\_ SSN : \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Address if different: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Physician/Clinic: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Clinic/Eye Doctor's Name: \_\_\_\_\_

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: \_\_\_\_\_ Do you wear prescription Sun Wear: Yes/No

Are you interested in contacts? Yes No Do you wear contacts? Yes No Type: \_\_\_\_\_

Solution Used: \_\_\_\_\_ Wearing schedule: **Daily** **Overnight**

Replacement schedule: **Daily** **2 week** **Monthly** **Yearly** Are you interested in lasik? Yes No

Have you ever had eye injuries? Yes No Which Eye? \_\_\_\_\_

Have you ever had eye surgeries? Yes No Why? \_\_\_\_\_

Have you used eye medication? Yes No Why? \_\_\_\_\_

Are you currently pregnant or nursing? Yes No N/A

### Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed? \_\_\_\_\_

Glaucoma: Yes/No When were you diagnosed? \_\_\_\_\_

Macular Degeneration: Yes/No When were you diagnosed? \_\_\_\_\_

### What are your visual symptoms: Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Blurred Vision/Distance | <input type="checkbox"/> Dry Eyes          | <input type="checkbox"/> Headaches            |
| <input type="checkbox"/> Blurred Vision/Near     | <input type="checkbox"/> Red Eyes          | <input type="checkbox"/> Migraine Headaches   |
| <input type="checkbox"/> Double Vision           | <input type="checkbox"/> Watery Eyes       | <input type="checkbox"/> Loss of Vision       |
| <input type="checkbox"/> Eye Strain              | <input type="checkbox"/> Wandering eye     | <input type="checkbox"/> Crossed Eyes         |
| <input type="checkbox"/> Eye Infections          | <input type="checkbox"/> Mucus Discharge   | <input type="checkbox"/> Light Sensitive      |
| <input type="checkbox"/> Eye Pain/Soreness       | <input type="checkbox"/> Floaters or Spots | <input type="checkbox"/> Sandy/Gritty Feeling |
| <input type="checkbox"/> Tired eyes              | <input type="checkbox"/> See Flashes       | <input type="checkbox"/> Poor Color Vision    |
| <input type="checkbox"/> Burning Eyes            | <input type="checkbox"/> See Halos         | <input type="checkbox"/> Droopy Lid           |
| <input type="checkbox"/> Itchy Eyes              | <input type="checkbox"/> Poor Night Vision |   |

**PERSONAL MEDICAL HISTORY ( REVIEW OF SYSTEMS ) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.**

<b>Cardiovascular:</b> __ None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other:	<b>Endocrine:</b> __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	<b>Respiratory:</b> __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
<b>Constitutional:</b> __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	<b>Ocular</b> __ None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	<b>Psychiatric:</b> __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
<b>Neurological:</b> __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	<b>Musculoskeletal:</b> __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	<b>Immunologic:</b> __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
<b>Hematological:</b> __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	<b>Gastrointestinal</b> __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	<b>Ear/Nose/Throat:</b> __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
<b>Dermatologic:</b> __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	<b>Allergies (please list)</b> __ None Drug:  Environmental:	<b>Alcohol Use:</b> Y       N Amount:  <b>Tobacco Use:</b> Y       N Amount:

Please list physical reaction's to above allergies: \_\_\_\_\_

Please list any medications and/or drugs that you are taking (including herbal) : \_\_\_\_\_ See Attached List: \_\_\_\_\_

1 _____ For _____	6 _____ For _____
2 _____ For _____	7 _____ For _____
3 _____ For _____	8 _____ For _____
4 _____ For _____	9 _____ For _____
5 _____ For _____	10 _____ For _____

**FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:**  
**DISEASE / CONDITION**

Retinal Detachment: Yes/No _____	Blindness: Yes/No _____
High Blood Pressure: Yes/No _____	Cataracts: Yes/No _____
Diabetes: Yes/No _____	Glaucoma: Yes/No _____
Cancer: Yes/No _____	Crossed Eyes: Yes/No _____
Heart Disease: Yes/No _____	Macular Degeneratiot Yes/No _____
Thyroid Disease: Yes/No _____	Lupus Yes/No _____

Reviewed by:

Dr \_\_\_\_\_ Date \_\_\_\_\_