Welcome Back!

Date____/____/_____

Last Name_____ First Name_____ MI____ DOB:___/___/_____

M or F SSN:____/___/_____ Marital Status: Married / Single / Divorced / Widowed Birth State:___

Height:____ **Weight**____ **Race:** White, American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, Other Race, Decline **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline

Address: _____ City: _____ State:_____ Zip:_____

Home Ph:( )_____-_____ Work Ph:( )_____-_____ Ext: ____ Cell Ph:( )_____-_____

E-mail Address:_____ Mother's Maiden Name: _____

Employer/School: _____ Occupation/ School Grade: _____

Sports/Hobbies:_____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail

Emergency Contact:_____ Relation:_____ Phone #:( )_____-_____

What are your visual symptoms today: Please circle any that apply, and indicate which eye(s):

[ ]Blurred Vision/Distance	R L B	[ ]Dry Eyes	R L B	[ ]Headaches	R L B
[ ]Blurred Vision/Near	R L B	[ ]Red Eyes	R L B	[ ]Migraine Headaches	R L B
[ ]Double Vision	R L B	[ ]Watery Eyes	R L B	[ ]Loss of Vision	R L B
[ ]Eye Strain	R L B	[ ]Wandering Eye	R L B	[ ]Crossed Eyes	R L B
[ ]Eye Infections	R L B	[ ]Mucus Discharge	R L B	[ ]Light Sensitive	R L B
[ ]Eye Pain/Soreness	R L B	[ ]Floaters or Spots	R L B	[ ]Gritty Feeling	R L B
[ ]Tired Eyes	R L B	[ ]See Flashes	R L B	[ ]Poor Color Vision	R L B
[ ]Burning Eyes	R L B	[ ]See Halos	R L B	[ ]Droopy Lid	R L B
[ ]Itchy Eyes	R L B	[ ]Poor Night Vision	R L B		

Please List anything in YOUR MEDICAL HISTORY not listed on your previous form.

Cardiovascular: __None __Stroke __Heart Disease __Hypertension __Other	Endocrine: __None __Diabetes __Thyroid __Diabetes Suspect __Other	Respiratory: __None __Asthma __COPD __Bronchitis __Other
Genitourinary: __None __Pregnancy __STDs __Prostate Disorder __Other	Ocular: __None __Glaucoma __Detached Retina __ARMD __Other	Psychiatric: __None __ADHD __Schizophrenia __Depression __Other
Neurological: __None __Epilepsy __MS __MD __Other	Musculoskeletal: __None __Arthritis __Fibromyalgia __Osteoporosis __Other	Immunologic: __None __AIDS __Lupus __RA __Other
Hematological: __None __Anemia __Leukemia __Cancer __Other	Gastrointestinal: __None __Crohn's __Acid Reflux __Colitis __Other	Ear/Nose/Throat: __None __Hearing Loss __Sinusitis __Trauma __Other
Dermatologic: __None __Eczema __Rosacea __Psoriasis __Other	Allergies to: __None Drug_____ Environmental_____	Alcohol Use: Yes / No Tobacco Use: Yes / No

Please List ALL MEDICATIONS you take: _____

_____

Have you had any eye related injuries, diseases or surgery since your last visit? ___Yes ____No

Reviewed by: Dr_____ Date_____