Pinnacle Eye Group

Last Name_____ First Name_____ MI_____DOB:___/___/_____

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

Birth State:_____ Sports/Hobbies:_____ Mother's Maiden Name: _____

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

Height:_____ Weight_____ Preferred Language: English / Spanish / Other:_____

Address: _____ City: _____ State:_____ Zip:_____
Home Ph:( )_____-_____ Work Ph:( )_____-_____ Ext: ____ Cell Ph:( )_____-_____

Employer/School: _____ Occupation/ School Grade: _____

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

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

Mother's Name: _____ SSN:_____/_____/_____

Address if different:_____

Father's Name: _____ SSN:_____/_____/_____

Address if different:_____

How did you hear about our office?_____ Are you currently pregnant or nursing? Yes / No / N/A

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? _____ years 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 an eye injury? Yes / No : Right / Left

Have you ever had eye surgeries? Yes / No Why?_____

Have you used eye medication? Yes / No Why?_____

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 today: Please circle any that apply:

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

[ ]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 turn over and complete other side*****

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

Cardiovascular: **__None** __Hypertension (High Blood Pressure) __High Cholesterol __Stroke __Heart Disease __Other:	**Endocrine:** **__None** __Non-Insulin Dependent Diabetes __Insulin Dependent Diabetes __Thyroid Problem __Hormonal Dysfunction __Other:	**Respiratory:** **__None** __Asthma __Bronchitis __Emphysema __COPD __Other:
Constitutional: **__None** __Cancer __Trauma/Large Volume Blood Loss __Developmental Disability __Other:	**Ocular:** **__None** __ Glaucoma __Macular Degeneration __Detached Retina __Other:	**Psychiatric:** **__None** __ADHD __Depression __Schizophrenia __Other:
Neurological: **__None** __Multiple Sclerosis __Epilepsy __Cerebral Palsy __Tumor __Other:	**Musculoskeletal:** **__None** __Osteoarthritis __Fibromyalgia __Muscular Dystrophy __Ankylosing Spondylitis __Other:	**Immunologic:** **__None** __AIDS or HIV __Rheumatoid Arthritis __Lupus __Neurofibromatosis __Other:
Hematological: **__None** __ Anemia __ Leukemia __ Other:	**Gastrointestinal:** **__None** __Crohn's __Colitis __Other:	**Ear/Nose/Throat:** **__None** __Hearing Loss __Upper Respiratory Infection __Other:
Dermatologic: **__None** __Eczema __Rosacea __Psoriasis __Other:	**DrugAllergies:**(please list) **__None** Environmental Allergies:	**Alcohol Use:** **Yes / No** Amount: **Tobacco Use:** **Yes / No** Amount:

Please list physical reactions 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:	Y / N		Blindness:	Y / N	
High Blood Pressure:	Y / N		Cataracts:	Y / N	
Diabetes:	Y / N		Glaucoma:	Y / N	
Cancer:	Y / N		Crossed Eyes:	Y / N	
Heart Disease:	Y / N		Macular Degeneration:	Y / N	
Thyroid Disease:	Y / N		Lupus	Y / N	

Reviewed by:

Dr_____ Date:_____