

**WELCOME TO PROGRESSIVE EYE CARE**

**DATE:**    /    /

Patient Name: \_\_\_\_\_ Age: \_\_\_\_ DOB: \_\_\_\_\_ Gender: M F

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**YOUR EYE HISTORY**

When was your last eye examination? \_\_\_\_\_

Previous Eye Doctor: \_\_\_\_\_

What are your main concerns today? (Reasons for visit)

Have you had a previous eye disease, injury or surgery?

Yes  No (If yes, please describe)

What is your occupation? \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

If you wear contact lenses, are you satisfied with your vision and end-of-day comfort?

Yes  No

Are you interested in finding out if laser vision correction is right for you?

Yes  No

Are you experiencing any of the following?

**Yes No**

- Blurred Vision
- Tired Eyes
- Double Vision
- Flashes of Light
- Floaters
- Dryness
- Redness
- Sandy or Gritty Feeling
- Burning
- Excessive Watering
- Itching
- Mucous Discharge
- Eye Pain or Soreness
- Chronic Infection of Eye or Lid
- Amblyopia (lazy eye)
- Glaucoma
- Macular degeneration
- Cataracts

**YOUR MEDICAL and SOCIAL HISTORY**

Your medical doctor \_\_\_\_\_

Date of Last Medical Examination \_\_\_\_\_

Do you have any **allergies to medications**?  Yes  No If yes, please list: \_\_\_\_\_

**List the medications you take** (including eye drops, contraceptives, over-the-counter, or herbal treatments): \_\_\_\_\_

Are you currently pregnant or nursing?  Yes  No If pregnant, how far along? \_\_\_\_\_

Do you drink alcohol?  Yes  No Do you smoke?  Yes  No

**REVIEW OF SYSTEMS: Please indicate if YOU have medical problems in the following areas:**

System	YES	NO	System	YES	NO	System	YES	NO
<b>Constitutional</b>			<b>Respiratory</b>			<b>Lymphatic, Hematologic</b>		
Fever, Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<b>Neurological</b>			Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cardiovascular</b>			<b>Immunologic</b>		
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive / AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<b>Psychiatric/Psychological</b>		
<b>Endocrine</b>			High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<b>Gastrointestinal</b>			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears, Nose, Mouth, Throat</b>			Stomach Ulcers / other	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<b>Bones, Joints, Muscles</b>			<b>Other</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	Muscle or Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b> _____	<input type="checkbox"/>	<input type="checkbox"/>
Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			

**FAMILY MEDICAL HISTORY Do your parents, grandparents, or siblings have the following?**

Disease/Condition	YES	NO	Relationship	Disease/Condition	YES	NO	Relationship
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>		Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>		High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	
Amblyopia (lazy eye)	<input type="checkbox"/>	<input type="checkbox"/>		Other _____			

<b>How did you hear about us?</b>	INSURANCE COMPANY	REFERRED BY DR. _____	WEBSITE	YELLOW PAGES	MONEY MAILER
	FRIEND, WHO? _____	OTHER _____			