::Welcome to eyewise optometry ::

Date:_____Mr.❑ Mrs.❑ Ms.❑ Dr.❑ Other (please specify): _____
Name: (*last*) _____ (*first*) _____ (*middle*) _____
Name I like to be called:_____ Parent/Guardian Name:_____
Street Address: _____
City:_____State:_____Zip Code _____
Home Telephone:_____Mobile Telephone:_____Work Telephone:_____
Date of Birth:_____Age:_____Social Security Number:_____Sex:_____
Occupation:_____Employer:_____
Vision Care Insurance: _____Email Address:_____
Primary Medical Insurance:_____Primary Care Physician:_____
Whom may we thank for referring you to our practice?_____
What is the main reason for your visit?_____
Do you wear glasses?_____ Are you interested in glasses today?_____
Do you wear contact lenses?_____Are you interested in contact lenses today?_____
Do you have any questions about refractive surgery (ex: LASIK)? _____

Past, Family and/or Social History

Is there anything in your past history, family history or social history which would help us care for you?

- Past History (illnesses, operations, injuries, medications, treatments) ❑Y ❑N
  If yes, please explain:_____
- Family History (diseases, hereditary, risk factors, glaucoma) ❑Y ❑N
  If yes, please explain:_____
- Social History (past and current activities)
  Do you use any of the following products: Tobacco ❑Y ❑N
  Alcohol ❑Y ❑N
  Recreational Drugs ❑Y ❑N

Review of Systems: Do you have a problem with ...

Eyes	**Y**	**N**	**Allergic/Immunologic**	**Y**	**N**	**Hematologic/Lymphatic**	**Y**	**N**
Blindness	❑	❑	HIV	❑	❑	Anemia	❑	❑
Loss of vision	❑	❑	Hay fever	❑	❑	Bleeding problems	❑	❑
Distorted vision	❑	❑	Medicine allergies	❑	❑	Swelling	❑	❑
Blurred vision	❑	❑	**Constitutional Symptoms**			**Integumentary**		
Double vision	❑	❑	Fever	❑	❑	Skin	❑	❑
Cataracts	❑	❑	Weight loss	❑	❑	Breast	❑	❑
Crossed eyes	❑	❑	**Cardiovascular**			**Musculoskeletal**		
Flashes or floaters	❑	❑	Heart pain	❑	❑	Arthritis	❑	❑
Dry eyes	❑	❑	High blood pressure	❑	❑	Rheumatoid arthritis	❑	❑
Watery eyes	❑	❑	Vascular disease	❑	❑	Muscle pain	❑	❑
Red eyes	❑	❑	**Ears, Nose, Mouth, Throat**			Joint pain	❑	❑
Mucous discharge	❑	❑	Sinus problems	❑	❑	**Neurological**		
Burning or itching	❑	❑	Chronic cough	❑	❑	Headaches	❑	❑
Sandy or gritty feeling	❑	❑	Dry throat/mouth	❑	❑	Migraines	❑	❑
Eye pain or soreness	❑	❑	Chronic ear infections	❑	❑	Seizures	❑	❑
Glare/light sensitivity	❑	❑	**Endocrine**			**Psychiatric**		
Chronic eye infections	❑	❑	Diabetes	❑	❑	Nervous disorders	❑	❑
Tired eyes	❑	❑	Thyroid problems	❑	❑	Depression	❑	❑
Halos	❑	❑	Other glands	❑	❑	Compulsive behavior	❑	❑
Vision therapy	❑	❑	**Gastrointestinal**			**Respiratory**		
Eye surgery	❑	❑	Ulcers	❑	❑	Asthma	❑	❑
Eye injury	❑	❑	Constipation	❑	❑	Shortness of breath	❑	❑
Retinal detachment	❑	❑	**Genitourinary**			Emphysema	❑	❑
Glaucoma	❑	❑	Genitals/kidneys/bladder	❑	❑	Lung cancer	❑	❑

Please list all medications and any additional pertinent information:

_____

_____

_____