Today's Date: _____

winking bee OPTOMETRY

Patient Name: _____ Birthdate: _____ **Patient History and Information**

Primary Care Physician:				Physician Phone:		
Physician Address:						
Today's Visit						
Complaint (main reason for today's visit):					Which eye (circle) Left / Right / Both	
Onset (when did it start?)		Duration (how long does it last?)		Timing (how often does it occur?)		
Context (when do you notice it?)		How Severe?		Modifying Factors (What makes it feel better?)		
Circle all that apply:	Blurred vision	Night blur	Double vision	Itchiness	Tearing	Secretion
	Redness	Pain	Tired eyes	Squinting	Light flashes	Floating spots
	Eye strain	Dizziness	Eye injury(ies)	Dry Eyes	Light sensitivity	
Have you ever:	Use tobacco	Drink alcohol	Use narcotics			

Medical and Eye History					
Any of the following conditions?	*Self*		*Family*		which family member?
Age Related Macular Degeneration	Y	N	Y	N	
Glaucoma	Y	N	Y	N	
Amblyopia / Strabismus / Lazy Eye	Y	N	Y	N	
Retinal Disease	Y	N	Y	N	
Cataracts	Y	N	Y	N	
High Cholesterol	Y	N	Y	N	
Cancer	Y	N	Y	N	
Diabetes	Y	N	Y	N	
High Blood Pressure	Y	N	Y	N	
Hyper or Hypothyroidism (please circle which)	Y	N	Y	N	
Heart Disease	Y	N	Y	N	
Sleep Apnea	Y	N	Y	N	
Psychiatric	Y	N	Y	N	
Other	Y	N	Y	N	

Your History						
Last Eye Exam:		Eye Surgeries?	Y	N	Headaches?	Y N
		What / When / Where?			When/How often?	
Pregnant?	Y N	Interested in Laser Vision			Interested in Ortho-K	
Nursing?	Y N	correction (LASIK)	Y	N		Y N
List all current medications (including vitamins)						
Allergies to medications:						
Do you have any special needs our office should know about?						

Contact Lenses			
Do you ever wear Contact Lenses? Y N	Are you interested in Contact Lenses? Y N	How often do you wear Contact Lenses? Daily / 1-2x WK / 1-2x MO	
Current Contact Lenses (Circle) Disposable / Bifocal / RGP / Hybrid / other		How often do you replace your contact lenses?	
Wear time today:	Average wear time:	Performance (do they work well?)	
		Do you rub your contact lenses when cleaning them?	
Solutions:			