Eye Associates of Alexandria

Date: ______/______/_______

Last Name: ____________________________ First Name:_________________________________ MI_____

Preferred Name:___________________Birthdate: _____/______/______ Preferred Language:____________

Circle **ONE**: Caucasian Hispanic/Latino Indian African American Asian Multiracial

M or F SSN:______/_______/_______ Marital Status:________________ Spouse:_______________

Address: _______________________________ City:_________________ State:__________ Zip:_________

Home Ph: ( )________________ Work Ph: ( ) __________________ Cell Ph: ( ) ___________________

Employer: ___________________________________ Occupation: ______________________ Student: Y/N

E-mail Address: ____ Sports/Hobbies: _____________________

Parents or Responsible Party:____

Who referred you to our office? ____

Date of Last Medical Exam: _____/______/______ Primary Physician /Clinic: _____________________

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? _______________________ Do you wear prescription sun wear? Yes / No

Do you wear contacts? Yes No Type: _____________________ Solution Used: ______________________

Wearing schedule: **Daily** **Overnight** Replacement schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had eye injuries? Yes No Which eye?_____________________________________

Have you ever had eye surgery? Yes No Why? ____

Have you used eye medications? 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? _________________________________

Detached Retina Yes / No When were you diagnosed? _________________________________

What are your visual symptoms: Please check any that may apply:

[ ] No Visual Symptoms
[ ] Blurred Vision/Distance
[ ] Blurred Vision/Near
[ ] Double Vision
[ ] Eye Strain
[ ] Eye Infections
[ ] Eye Pain/Soreness
[ ] Tired Eyes
[ ] Burning Eyes
[ ] Itchy Eyes
[ ] Dry Eyes
[ ] Red Eyes
[ ] Watery Eye
[ ] Wandering Eye
[ ] Mucus Discharge
[ ] Floaters or Spots
[ ] See Flashes
[ ] See Halos
[ ] Poor Night Vision
[ ] Headaches
[ ] Migraine Headaches
[ ] Loss of Vision
[ ] Crossed Eyes
[ ] Light Sensitive
[ ] Sandy/Gritty Feeling
[ ] Poor Color Vision
[ ] Droopy Lid

MORE ON OTHER SIDE⇒

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Constitutional	**Respirator**	**Endocrine:**
____Cancer ____Developmental Disability ____Fatigue Syndrome ____Dementia/ Alzheimer's ____Other: ____**None**	____Asthma __ Sleep Apnea ____Bronchitis ____Emphysema ____COPD ____Other: ____**None**	____Type I Diabetes ____Type II Diabetes ____Thyroid Problems ____Hormonal Dysfunction ____Other: ____**None**
Ear/Nose/Throat ____Hearing Loss ____Sinusitis ____Upper Respiratory ____Laryngitis ____Other: ____**None:**	**Gastrointestinal:** ____Celiac Disease ____Crohn's ___Acid Reflux ____Colitis ____Ulcer ____Other: ____**None**	**Genitourinary:** ____Kidney Disease ___ Herpes ____Nursing ___Pregnant ____STD ___Chlamydia ____Prostate Disease/Cancer ____Other: ____**None**
Neurological: ____Multiple Sclerosis ____Epilepsy ___Migraine ____Cerebral Palsy ____Tumor ____Other: ____**None**	**Musculoskeletal:** ____Osteoarthritis __ Osteoporosis ____Fibromyalgia __ Arthritis ____Muscular Dystrophy __ Gout ____Ankylosing Spondylitis ____Other: ____**None**	**Hematological/ Lymphatic:** ____Anemia ____Large Volume Blood Loss ____High Cholesterol ____Ulcer ____Other: ____**None**
Psychiatric: ____ADHD/ADD __ Anxiety ____Depression ____Schizophrenia ____Bipolar ____Other: ____**None**	**Dermatologic/ Integumentary:** ____Eczema ___ Rosacea ____Psoriasis ____Herpes Simplex/Cold Sores ____Herpes Zoster/Shingles ____Other: ____**None**	**Immune:** ____AIDS or HIV ____Rheumatoid Arthritis ____Lupus ____Neurofibromatosis ____Other: ____**None**
Cardiovascular: ____Hypertension (High Blood Pressure) ____Stroke ____Heart Disease ____Vascular Disease ____Other: ____**None**	**Are you Allergic to any medications/ Drugs?** If so, please list: ___ **None**	**Do you Have Any Environmental Allergies?** If so, please list: ____ **None**

Alcohol Use: Y N **Tobacco Use: Y N** **Please Circle 1:** Former Smoker Never Smoked
Amount: Amount: Current Smoker Smokes Everyday
Smokes Somedays

Please list any medications and/or drugs that you are taking and dosage :

1 ____________________ Dosage_____________ 6___________________Dosage_______________
2_____________________Dosage_____________ 7 ___________________Dosage ______________
3_____________________Dosage_____________ 8___________________Dosage______________
4_____________________Dosage_____________ 9 __________________ Dosage ______________
5_____________________Dosage_____________ 10 _________________ Dosage _______________

Family History: Has anyone in your family (parents, siblings, children, living or deceased) been diagnosed with:

Lupus Yes/No__________________ Cataracts Yes/No________________
Cancer: Yes/No_________________ Glaucoma Yes/No_________________
Diabetes: Yes/No_________________ Crossed Eyes Yes/No_________________
High Blood Pressure: Yes/No__________________ Macular Degeneration Yes/No_________________
Thyroid Disease Yes/No___________________ Retinal Detachment: Yes/No ________________
Other: Yes/No___________________