DOWNTOWN FAMILY VISION

Medical History / Review of Systems

Name: _____ Date Of Birth: ____/_____/_____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____Work Phone: _____

Email: _____ Sex: M/F

Medical Insurance: _____ Vision Insurance _____

Social Security Number: _____-_____-_____ Occupation: _____

Primary Language: _____ Preferred Communication: Text Phone Email

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic/Latino ☐ Decline

Race: ☐American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian

☐ Other ☐ White ☐ Decline

Prescription Drug Allergies:_____

Medications: _____

Previous eye surgeries?_____

Primary Physician: _____Preferred Pharmacy:_____

Are you pregnant and / or nursing? ☐ yes ☐no

Do you wear glasses? ☐ yes ☐ no **If yes, how old is your present pair of glasses? _____**

Do you wear contact lenses? ☐ yes ☐ no

Type of contact lenses: ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other **Are they comfortable?** ☐ yes ☐ no

Please indicate your reasons for visiting our office today: (check all that apply)

- ☐ General Exam (Comprehensive Eye Examination without Contact Lens Evaluation)
- ☐ Contact Lens Evaluation (Comprehensive Eye Examination, Contact Lens Evaluation and Contact Lens Fitting)
- ☐ Blurred Vision
- ☐ Other: _____

Who may we thank for referring you to our office? _____

Family History

Please note any **family history** (parents, grandparents, siblings, children; living or deceased) for the following:

DISEASE / CONDITION	No	Yes	?	RELATIONSHIP TO YOU
Blindness	☐	☐	☐	_____
Cataract	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other Inherited Disease	☐	☐	☐	_____

_____

Social History

(This information is kept strictly confidential. However, you may discuss directly with the doctor if you prefer)

☐Yes, I would prefer to discuss my social history information directly with my doctor (check box)

Do you drive? ☐ yes ☐ no **If yes, do you have visual difficulty when driving?** ☐ yes ☐ no

Do you use tobacco products? ☐ yes ☐ no **If yes, how much and how often?** _____

Do you drink alcohol? ☐ yes ☐ no **If yes, how often?** _____

Do you use illegal drugs? ☐ yes ☐ no **If yes, how often?** _____

We are occasionally asked for a contact lens prescription after a general eye examination or after the initial contact lens fitting visit. Determining your exact contact lens prescription requires a more specialized method of testing that is not involved in a general eye examination. Your prescription cannot be finalized until the contact lenses have been worn for a period of time to ensure that no lens design changes will be needed. After the completion of one week of successful contact lens wear monitored by a progress visit, we will release the final contact lens prescription upon request. If you have any questions about contact lenses, please ask our staff or the doctor.

ALL PRESCRIPTIONS FOR GLASSES AND GLASSES EXPIRE IN 1 YEAR, AND WILL NOT BE RELEASED THEREAFTER.

_____ _____

Patient, Parent or Guardian Signature (if under age of 19) Date

Review of Systems

Do you currently, or have you ever had any **chronic** problems in the following areas?

SYSTEM	NO	YES	?
GENERAL/CONSTITUTIONAL			
Fever, Weight Loss/Gain	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Blurred Vision	☐	☐	☐
Distorted Vision / Halos	☐	☐	☐
Loss of Side Vision	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Flashes / Floaters	☐	☐	☐
Tired Eyes	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy / Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Glare / Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye	☐	☐	☐
Sties or Chalazion	☐	☐	☐
ENDOCRINE			
Thyroid / Other Glands	☐	☐	☐
Diabetes	☐	☐	☐
PSYCHIATRIC			
Depression	☐	☐	☐
Anxiety	☐	☐	☐
ADHD	☐	☐	☐

SYSTEM	NO	YES	?
EARS,NOSE,MOUTH,THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose	☐	☐	☐
Post-nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Tuberculosis	☐	☐	☐
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
VASCULAR / CARDIOVASUCLAR			
Stroke	☐	☐	☐
Heart Disease	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals /Kidney /Bladder	☐	☐	☐
BONES / JOINTS /MUSCLES			
Joint Pain	☐	☐	☐
Muscle Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC			
Hepatitis	☐	☐	☐
High Cholesterol	☐	☐	☐
ALLERGIC / IMMUNOLOGIC			
Environmental	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Lupus	☐	☐	☐
Sjogrens	☐	☐	☐
Other	_____		