Dr. Fred Slater, Optometrist

"FOR OUR NEW PATIENTS," WE APPRECIATE THE OPPORTUNITY TO SERVICE YOUR EYECARE NEEDS. PLEASE HELP US BY COMPLETING THE FOLLOWING INFORMATION SHEET.
"FOR OUR PREVIOUS PATIENTS," WELCOME BACK! PLEASE COMPLETE THE FOLLOWING INFORMATION SHEET SO WE CAN VERIFY YOUR MOST CURRENT INFORMATION.

Last Name:____________________ First Name:____________________ Today's Date: __________

Address: ______________________________ Home Phone: __________

City:____________________ State: ______ Zip: __________ Cell Phone: __________

Guardian (If Applicable): ______________________________ Occupation: __________

Birth Date:__________ Age:____ Member ID # __________ Last Eye Exam:__________

Name of Medical Doctor: ______________________________ Dr.'s Phone: __________

How were you referred to us?: ______________________________ Last Medical Exam: __________

My exam is for (check all that apply): Routine Exam Glasses Sunglasses Contact Lenses LASIK Medical Eye Visit Other:__________

Medical History

Do you have any allergies to medications? no yes If yes, explain:

____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

____

____

List all major injuries, surgeries and/or hospitalizations you have had:

____

List any of the following that you have had: crossed eves, lazy eye, drooping eyelid, prominent eves, glaucoma, retinal disease, cataracts, eye infections or eye injury: ______________________________

Are you pregnant and/or nursing? no yes

Do you wear glasses? no yes If yes, how old is your present pair of lenses? __________

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? __________

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

Family History

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

DISEASE/CONDITION	PERSONALLY NO	PERSONALLY YES	PERSONALLY ?	FAMILY MEMBERS NO	FAMILY MEMBERS YES	FAMILY MEMBERS ?	RELATIONSHIP TO YOU
Blindness							
Cataract							
Crossed Eyes							
Glaucoma							
Macular Degeneration							
Retinal Detachment/Disease							
Arthritis							
Cancer							
Diabetes							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Lupus							
Thyroid Disease							
Other __________							

** Please turn this form over and complete side two **

Social History

This information is kept strictly confidential. However you may discuss this portion 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? no yes If yes, do you have visual difficulty when driving? no yes If yes, please describe:

____

Do you use tobacco products? no yes If yes, type/amount/how long: ______________________________

Do you drink alcohol? no yes If yes, type/amount/how long: ______________________________

Do you use illegal drugs? no yes If yes, type/amount/how long: ______________________________

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

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

SYSTEM	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies/Hay Fever			
Sinus Congestion			
Runny Nose			
Post-Nasal Drip			
Chronic Cough			
Dry Throat/Mouth			
RESPIRATORY			
Asthma			
Chronic Bronchitis			
Emphysema			
VASCULAR / CARDIOVASCULAR			
Diabetes			
Heart Pain			
High Blood Pressure			
Vascular Disease			
GASTROINTESTINAL			
Diarrhea			
Constipation			
GENITOURINARY			
Genitals/ Kidney/Bladder			
BONES / JOINTS / MUSCLES			
Rheumatoid Arthritis			
Muscle Pain			
Joint Pain			
LYMPHATIC / HEMATOLOGIC			
Anemia			
Bleeding Problems			
ALLERGIC / IMMUNOLOGIC			
PSYCHIATRIC			

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

____

____

____

____

____

______________________________ Doctor's Signature

______________________________ Date