



Welcome to **St. Anthony** Eye Clinic

Date: _____

Last Name: _____ First Name: _____ Date of Birth: _____

Sex: M / F Last 4 Digits of Soc.Sec.#: _____ Spouse: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ E-mail Address: _____

Home Ph:() _____ Work Ph:() _____ Cell Ph:() _____

Employer/School: _____ Occupation/School Grade: _____

Emergency Contact: _____ Relation: _____ Phone #:() _____

Vision & Medical Insurance, include ID numbers: _____

CASE HISTORY:

Date of Last Eye Exam: _____ Clinic/Eye Doctor's Name: _____

Do you wear Glasses? No / Yes: Full time / Part time / Work only / Driving only / Reading only

Do you wear Sunglasses? No / Yes: Prescription / Non-Prescription

Do you wear Contacts? No / Yes: Soft / Disposable / Gas Permeable (RGP). Brand: _____

If No, are you interested in trying contacts? Yes / No

Are you planning to get new glasses at this visit? Yes / If necessary / No

Do you have any difficulty driving or seeing well at night? Yes / No

Have you ever had an Eye Injury? No / Yes: Which eye? R / L Type of injury: _____

Have you ever had Eye Surgery? No / Yes: Why? _____

Do you currently use Eye Drops? No / Yes: Why? _____

Are you taking Vitamins for your eyes? No / Yes: Brand: _____

Have you ever been diagnosed with:

Cataracts? No / Yes: When? _____

Glaucoma? No / Yes: When? _____

Macular Degeneration? No / Yes: When? _____

Detached Retina? No / Yes: When? _____

Please Circle any Current Symptoms:

- | | | | |
|-------------------------|--------------|-------------------|----------------------|
| Blurred Vision/Distance | Burning Eyes | Floaters or Spots | Headaches |
| Blurred Vision/Near | Itchy Eyes | See Flashes | Eye Pain/Soreness |
| Double Vision | Dry Eyes | Loss of Vision | Droopy eyelid |
| Eye Strain | Red Eyes | Mucus Discharge | Light Sensitive |
| Tired eyes | Watery Eyes | Poor Color Vision | Sandy/Gritty Feeling |

PLEASE TURN THIS OVER AND COMPLETE SIDE TWO



MEDICAL HISTORY: CHECK ANY THAT APPLY. If none - CHECK 'None'

Cardiovascular: <input type="checkbox"/> None <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Other:	Endocrine: <input type="checkbox"/> None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	Respiratory: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
Constitutional: <input type="checkbox"/> None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	Dermatologic: <input type="checkbox"/> None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	Psychiatric: <input type="checkbox"/> None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
Neurological: <input type="checkbox"/> None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other:	Musculoskeletal: <input type="checkbox"/> None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	Immunologic: <input type="checkbox"/> None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
Hematological: <input type="checkbox"/> None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	Gastrointestinal: <input type="checkbox"/> None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	Ear/Nose/Throat: <input type="checkbox"/> None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
Allergies to Medications: <input type="checkbox"/> None Please List:	Allergies to Environmental or Seasonal Causes: <input type="checkbox"/> None Please List:	Alcohol Use: <input type="checkbox"/> N <input type="checkbox"/> Y Amount: _____ Tobacco Use: <input type="checkbox"/> N <input type="checkbox"/> Y Amount: _____

List physical reactions to above allergies: _____

Date of Latest Medical Exam: _____ Primary Physician/Clinic: _____

Women: Are you currently pregnant or nursing? N Y

Please list any medications and/or drugs that you are taking (including vitamins / herbals)

1 _____ For _____	6 _____ For _____
2 _____ For _____	7 _____ For _____
3 _____ For _____	8 _____ For _____
4 _____ For _____	9 _____ For _____
5 _____ For _____	10 _____ For _____

FAMILY HISTORY: Has anyone in your family been diagnosed with these DISEASES or CONDITIONS?:

Who? Grandparents, Parents, Siblings. (Include deceased relatives)

High Blood Pressure: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Blindness: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____
Diabetes: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Cataracts: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____
Cancer: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Glaucoma: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____
Heart Disease: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Crossed Eyes: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____
Thyroid Disease: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Macular Degeneration: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____
Lupus: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____	Retinal Detachment: <input type="checkbox"/> No / <input type="checkbox"/> Yes _____

Reviewed by:

Dr. _____ Date: _____ Dr. _____ Date: _____ Pt's Initials: _____ Date: _____