

Welcome Back!

Date ___/___/___

Last Name _____ First Name _____ MI _____ DOB: ___/___/___
 M or F SSN: ___/___/___ Marital Status: Married / Single / Divorced / Widowed
Height: ___ **Weight** ___ **Race:** White, American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, Other Race, Decline **Ethnicity:** Not Hispanic or Latino, Hispanic or Latino, Unknown, Decline
 Address: _____ City: _____ State: _____ Zip: _____
 Home Ph:() _____ - _____ Work Ph:() _____ - _____ Ext: _____ Cell Ph:() _____ - _____
E-mail Address: _____ Spouse/Guardian Name: _____
 Employer/School: _____ Occupation/ School Grade: _____
 Sports/Hobbies: _____ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail
 Emergency Contact: _____ Relation: _____ Phone #:() _____ - _____

What are your visual symptoms today: Please circle any that apply, and indicate which eye(s):

- | | | | | | |
|--|-------|--|-------|---|-------|
| <input type="checkbox"/> Blurred Vision/Distance | R L B | <input type="checkbox"/> Dry Eyes | R L B | <input type="checkbox"/> Headaches | R L B |
| <input type="checkbox"/> Blurred Vision/Near | R L B | <input type="checkbox"/> Red Eyes | R L B | <input type="checkbox"/> Migraine Headaches | R L B |
| <input type="checkbox"/> Double Vision | R L B | <input type="checkbox"/> Watery Eyes | R L B | <input type="checkbox"/> Loss of Vision | R L B |
| <input type="checkbox"/> Eye Strain | R L B | <input type="checkbox"/> Wandering Eye | R L B | <input type="checkbox"/> Crossed Eyes | R L B |
| <input type="checkbox"/> Eye Infections | R L B | <input type="checkbox"/> Mucus Discharge | R L B | <input type="checkbox"/> Light Sensitive | R L B |
| <input type="checkbox"/> Eye Pain/Soreness | R L B | <input type="checkbox"/> Floaters or Spots | R L B | <input type="checkbox"/> Gritty Feeling | R L B |
| <input type="checkbox"/> Tired Eyes | R L B | <input type="checkbox"/> See Flashes | R L B | <input type="checkbox"/> Poor Color Vision | R L B |
| <input type="checkbox"/> Burning Eyes | R L B | <input type="checkbox"/> See Halos | R L B | <input type="checkbox"/> Droopy Lid | R L B |
| <input type="checkbox"/> Itchy Eyes | R L B | <input type="checkbox"/> Poor Night Vision | R L B | | |

Please List anything in YOUR MEDICAL HISTORY not listed on your previous form.

Cardiovascular: _____None ___Stroke _____Heart Disease ___Hypertension _____Other	Endocrine: _____None ___Diabetes _____Thyroid ___Diabetes Suspect _____Other	Respiratory: _____None ___Asthma _____COPD ___Bronchitis _____Other
Genitourinary: _____None ___Pregnancy _____STDs ___Prostate Disorder _____Other	Ocular: _____None ___Glaucoma ___Detached Retina ARMD _____Other	Psychiatric: _____None ___ADHD _____Schizophrenia Depression _____Other
Neurological: _____None ___Epilepsy _____MS MD _____Other	Musculoskeletal: _____None ___Arthritis _____Fibromyalgia Osteoporosis _____Other	Immunologic: _____None ___AIDS _____Lupus RA _____Other
Hematological: _____None ___Anemia _____Leukemia Cancer _____Other	Gastrointestinal: _____None ___Crohn's _____Acid Reflux Colitis _____Other	Ear/Nose/Throat: _____None ___Hearing Loss _____Sinusitis Trauma _____Other
Dermatologic: _____None ___Eczema _____Rosacea Psoriasis _____Other	Allergies to: _____None Drug _____ Environmental _____	Alcohol Use: Yes / No Tobacco Use: Yes / No

Please List ALL MEDICATIONS you take: _____

Have you had any eye related injuries, diseases or surgery since your last visit? ___Yes ___No