

**General Information**

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Home Phone:( ) \_\_\_\_\_ Work Phone:( ) \_\_\_\_\_ SS#: \_\_\_\_/\_\_\_\_/\_\_\_\_

Cell Phone:( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Emergency Contact: Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone#:( ) \_\_\_\_\_

Date of Last Medical Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Physician/Clinic: \_\_\_\_\_

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

Employer/School: \_\_\_\_\_ Occupation/School Grade: \_\_\_\_\_

Sports/Hobbies: \_\_\_\_\_ Number of Children?: \_\_\_\_\_ Ages: \_\_\_\_\_

**I acknowledge that I am the financially responsible party for all procedures received at Elk River Eye Clinic**

\_\_\_\_\_  
(Patients Name) (Date)

**CASE HISTORY / REASON FOR VISIT:**

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type: \_\_\_\_\_ Replace Schedule: \_\_\_\_\_

Have you ever had eye injuries? Yes No Which Eye? \_\_\_\_\_

Have you ever had eye surgeries? Yes No Why? \_\_\_\_\_

Have you taken eye medication? 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? \_\_\_\_\_

**PLEASE CIRCLE AND EXPLAIN ANY OF THE FOLLOWING FOR PAST OR PRESENT CONDITIONS THAT APPLY**

- |                           |              |                   |                   |
|---------------------------|--------------|-------------------|-------------------|
| Blurred Vision - Distance | Burning Eyes | Floaters or Spots | Headaches         |
| Blurred Vision - Near     | Itchy Eyes   | See Flashes       | Migrane Headaches |
| Double Vision             | Dry Eyes     | See Halos         | Loss of Vision    |
| Eye Strain                | Red Eyes     | Poor Night Vision | Crossed Eyes      |
| Eye Infections            | Watery Eyes  | Poor Color Vision | Light Sensitive   |
- Are you currently pregnant or nursing? Yes No

**Notes:**

**\* PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE\***



**PERSONAL MEDICAL HISTORY ( REVIEW OF SYSTEMS ) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.**

<b>Cardiovascular:</b> __ None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> Vascular Disease <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Endocrine:</b> __ 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: <input type="checkbox"/> Medications:	<b>Respiratory:</b> __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other: <input type="checkbox"/> Medications:
<b>Constitutional:</b> __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Genitourinary:</b> __ None <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary Tract Infection <input type="checkbox"/> STD - Herpetic/Chlamydia <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Psychiatric:</b> __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other: <input type="checkbox"/> Medications:
<b>Neurological:</b> __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Tumor <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Musculoskeletal:</b> __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Immunologic:</b> __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other: <input type="checkbox"/> Medications:
<b>Hematological:</b> __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Gastrointestinal:</b> __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Ear/Nose/Throat:</b> __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other: <input type="checkbox"/> Medications:
<b>Dermatologic:</b> __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: <input type="checkbox"/> Medications:	<b>Allergies (please list)</b> __ None Drug:  Environmental:	<b>Alcohol Use:</b> Y    N Amount:  <b>Tobacco Use:</b> Y    N Amount:

Please list any medications and/or drugs that you are taking (including herbal) that are not listed above:

**FAMILY HISTORY:**

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

**DISEASE / CONDITION**

Blindness:	Y	N	Who? _____
Cataracts:	Y	N	Who? _____
Glaucoma:	Y	N	Who? _____
Crossed Eyes:	Y	N	Who? _____
Macular Degeneration:	Y	N	Who? _____
Retinal Detachment:	Y	N	Who? _____
High Blood Pressure:	Y	N	Who? _____
Diabetes:	Y	N	Who? _____
Cancer:	Y	N	Who? _____
Heart Disease:	Y	N	Who? _____
Thyroid Disease:	Y	N	Who? _____

**Reviewed by:**

Dr. \_\_\_\_\_ Date \_\_\_\_\_ Dr. \_\_\_\_\_ Date \_\_\_\_\_

