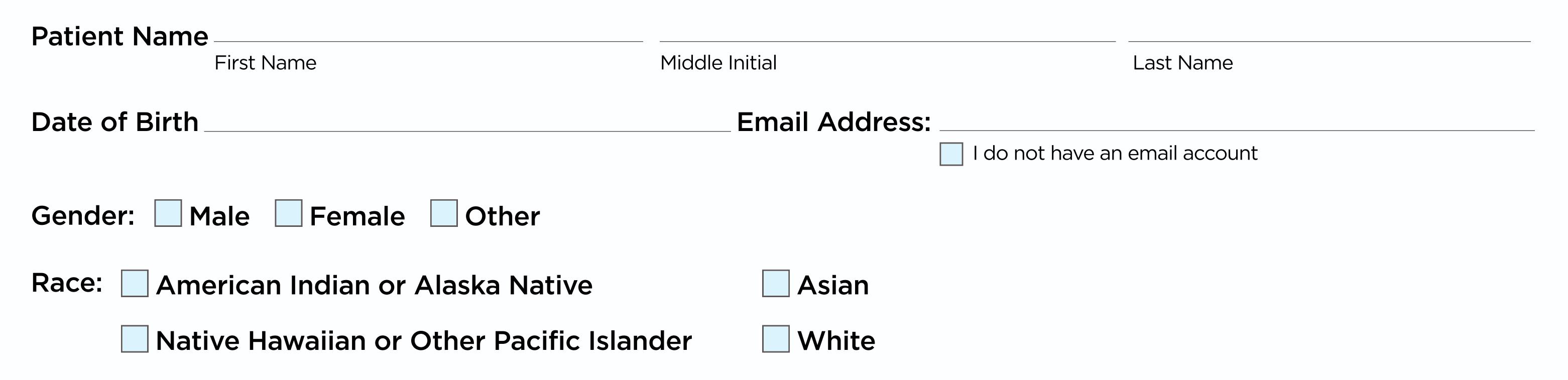
## Patient Information



Black or African American

## **Other Race**

Ethnicity: Hispanic or Latino Not Hispanic or Latino Unknown

## Who shall we contact in case of an emergency?

First Name	Last Name		
Home Phone ()	Relationship: Single Married Widowed Separated		
Work Phone	Cell Phone ()		



## • IF YOU HAVE EVER HAD AN OPERATION ON YOUR EYES, PLEASE FILL OUT ALL OF THE REQUESTED **INFORMATION.**

## IF YOU HAVE HAD NO EYE SURGERIES, SELECT "NONE" IN THE 'NAME OF PROCEDURE BOX."

Date of Surgery\_\_\_\_\_

Surgeon

Name of Procedure:

Cataract surgery

**Comeal Foreign Body** 

**Corneal Transplant** 

**Eyelid Surgery** 

**Glaucoma Surgery** 

aser treatment of retina

**Eye Muscle or Strabismus Surgery** 



Eyelash Removal



**Retinal Detachment** 



RK

# Ocular DIAGNOSIS OF GLAUCOMA?

**DIAGNOSIS OF CATARACTS?** 



**No** 

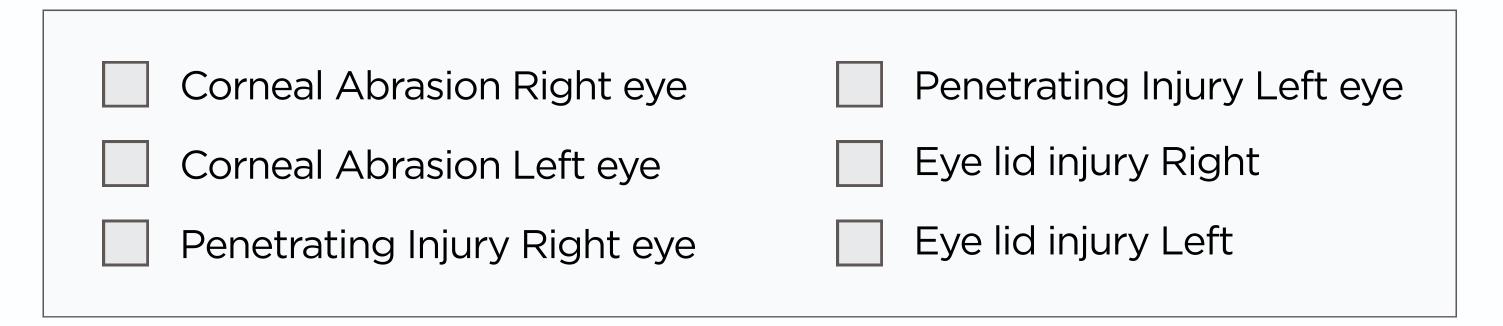
If yes, Check one:

Cataract removed right eye	Cataract removed both eyes
Cataract removed left eye	Beginning cataract

#### HAVE YOU EVER HAD AN EYE INJURY?



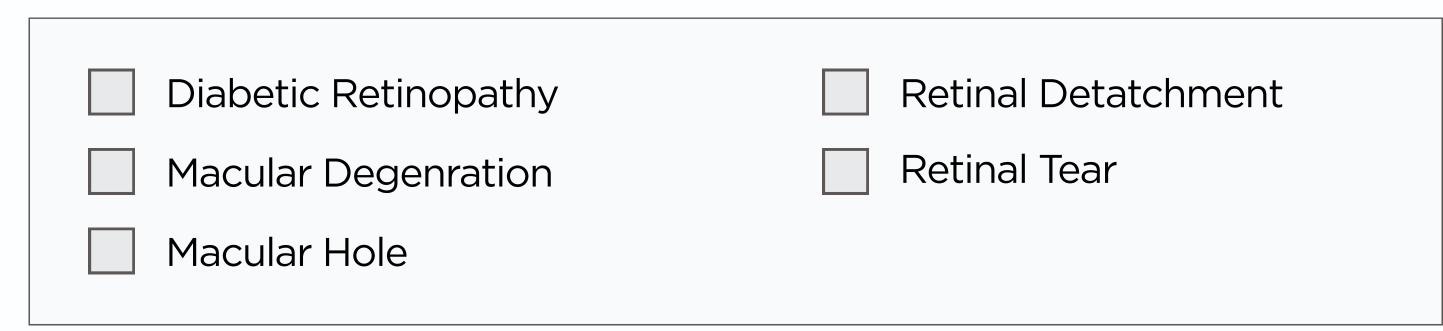
#### If yes, Check all that apply:



## DIAGNOSIS OF RETINAL DISEASE?

Yes No

If yes, Check all that apply:



#### **OTHER EYE DISEASES? CHECK ALL THAT APPLY:**



Enucleation Right Eye

Exophthalmos Both Eyes

Exophthalmos Left Eye Exophthalmos Right Eye

## DIAGNOSIS OF BLINDNESS / VISION LOSS?

If yes, Check all that apply:

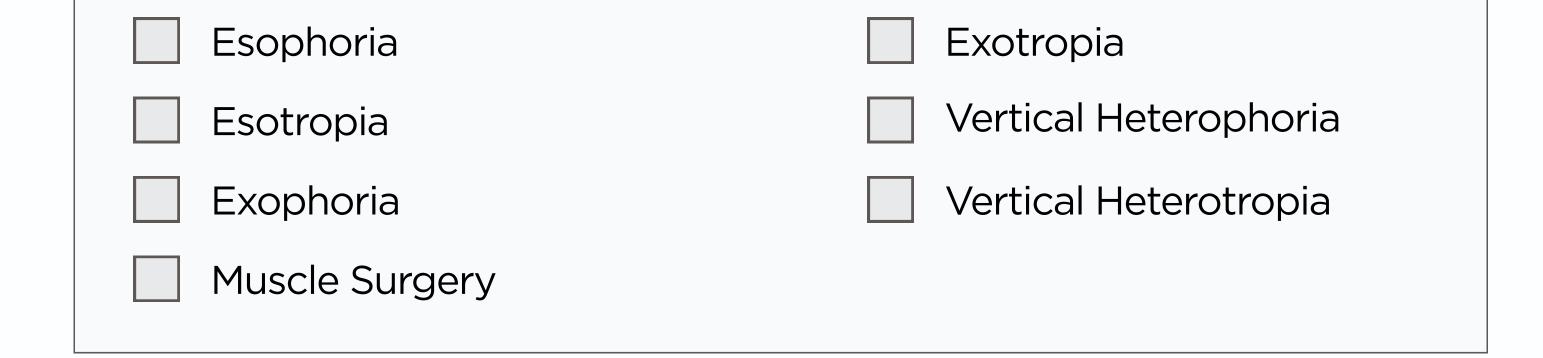
Congenital	Injury Related
Corneal Scar	Legally Blind
Enucleation	

**DIAGNOSIS OF STRABISMUS?** 



No

If yes, Check all that apply:



## **DIAGNOSIS OF AMBLYOPIA?**



If yes, Check all that apply:

Both Eyes	Treatment Management: Patching
One Eye	Treatment Management: Pharmaceutical
Treatment Management: Eye Muscle Surgery	Treatment Management: Vision Therapy
Treatment Management: Glasses	

## DO YOU HAVE OCULAR COMPLICATIONS RELATED TO DIABETES?



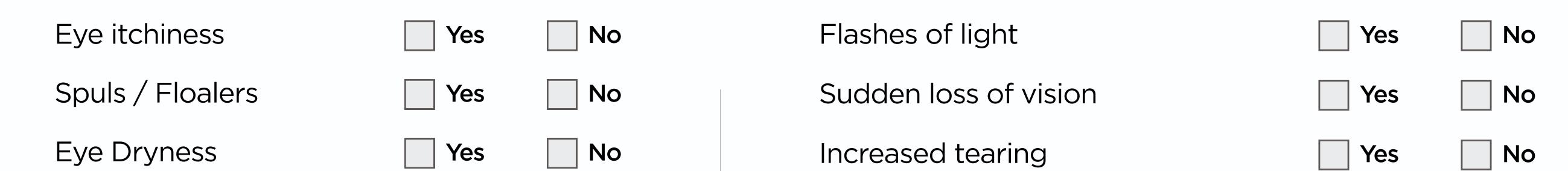
#### **DIAGNOSIS OF DRY EYE?**

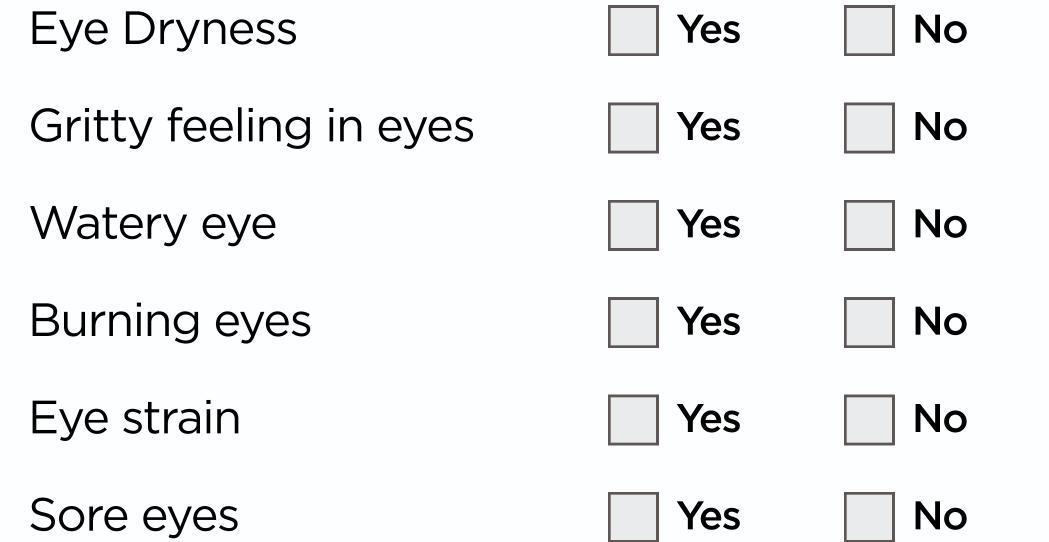


If yes, Check your level of severity:

Mild	
Moderate	
Severe	

#### **OTHER VISION SYMPTOMS**





Increased tearing	Ye
Redness	Ye
Trouble seeing at night	Ye
Trouble working up close	Ye
Trouble being fit with, or	

adjusting to a prior pair of glasses

Yes	No
Yes	No
Yes	No
Yes	No

## READING

Trouble learning at school, work or other activity

Trouble concentrating





## Last Eye Exam\_\_\_\_\_(MM/DD/YYYY) Dr Last Eye Exam\_\_\_\_\_

#### **DO YOU WEAR GLASSES?**

If yes, please answer the below questions:

Age when glasse	es were first worn (in years):			
Worn full or part	Worn full or part time? (choose one):		r both? (choose one):	
Full Time	Yes No	Far Vision Only	Yes No	

Part Time	Yes No	Near Vision Only	Yes	No	
		Both Far and Near	Yes	No	

#### **DO YOU WEAR CONTACT LENSES?**

If yes, please answer the below questions:

Yes	No
-----	----

No

Yes

Age when contac	cts first worn (in ye	ears):		
Worn full time or	r part time? (choos	;e one):		
Full Time	Yes	No		
Part Time	Yes	No		

#### DO YOU WORK AT A DESK OR ON A COMPUTER?



If yes, please answer the below questions:

Approximate distance from yo	ur eyes to the desk / computer screen (in inches):
How many hours per day?	
Are glasses worn? Yes	No

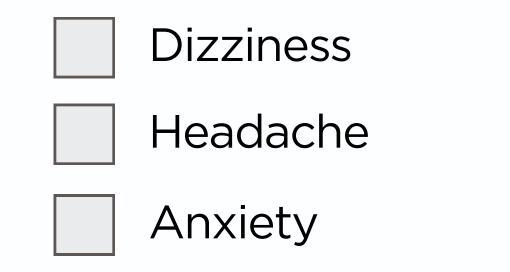
## DO YOU PERFORM DISTANCE VIEWING (10 FEET AND BEYOND - CLASSROOM, WORK, DRIVING)?



If yes, please answer the below questions:

How many hours per day?	
Are glasses worn?	Νο

## 1. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE WORST AND CAUSES YOU THE MOST PROBLEMS:





2. HOW LONG HAVE YOU HAD THIS WORSTSYMPTOM? (IN YEARS)\_\_\_\_\_

3. HOW SEVERE IS YOUR WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?

0 1 2 3 4 5 6 7 8 9 10

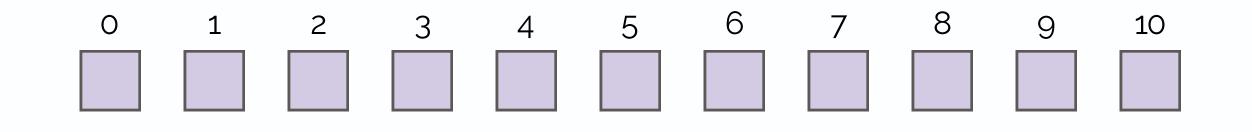


## 4. OF ALL OF YOUR SYMPTOMS, CHECK THE SYMPTOM THAT IS THE SECOND WORST:



## 5. HOW LONG HAVE YOU HAD THIS SECOND WORST SYMPTOM (IN YEARS)\_

## 6. HOW SEVERE IS YOUR SECOND WORST SYMPTOM, ON AN AVERAGE DAY, ON A 0-10 SCALE (WHERE 0 IS NO SYMPTOM AND 10 IS THE WORST IT COULD BE)?



## 7. PLEASE ANSWER WHETHER YOU HAVE HAD ANY OF THESE TESTS PERFORMED:



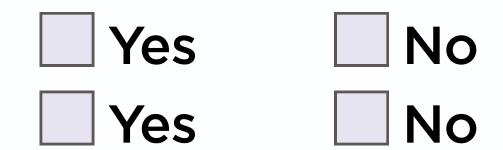
#### If Other list here:

## 8. PLEASE ANSWER WHETHER YOU HAVE SEEN ANY DOCTORS / SPECIALISTS / OTHER PROVIDERS FOR THESE SYMPTOMS?

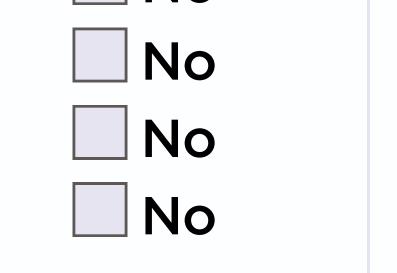
Internist ENT (Ears / Nose /Throat)



Reading Specialist Psychiatrist / Psychologist



Chiropractor	Yes
Family Practice	Yes
Neurologist	Yes
PM&R (Physical Medicine and Rehab.)	Yes



No

Pediatrician Ophthalmologist

Optometrist

Emergency Physician / ER

Yes
Yes
No
Yes
No
Yes
No

#### If Other list here: \_\_\_\_\_



#### HAVE YOU BEEN DIAGNOSED WITH A TRAUMATIC BRAIN INJURY (TBI)?



If yes, please answer the below questions:

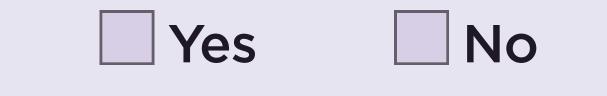
Who diagnosed you as having a TBI?\_\_\_\_\_

When did the TBI occur? Date:\_

Are you coming to Vision Specialists to be evaluated for symptoms that seem to have been caused by or seem to be related to TBI?

1. \_\_\_\_\_ 3. \_\_\_\_\_ 3. \_\_\_\_\_

1. \_\_\_\_\_ 2. \_\_\_\_ 3. \_\_\_\_



If headaches are a problem for you, please list your 3 worst headache triggers:

If dizziness is a problem for you, please list your 3 worst dizziness triggers:

Are you currently driving a car during the day?

Yes No

Are you currently driving a car at night?

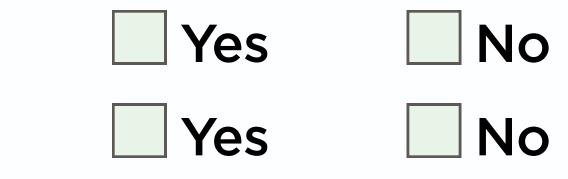


## Health History

## ENDOCRINE

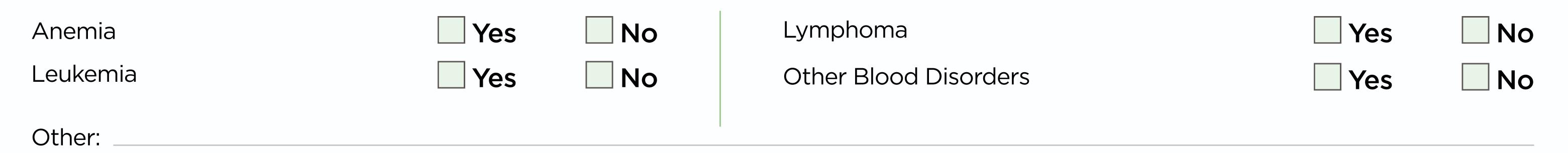
Thyroid Disorder	Yes	Νο
Diabetes	Yes	Νο
Adrenal Disorder	Yes	Νο

Female hormone replacement therapy





## HEMATOLOGIC / LYMPHATIC



## CARDIOVASCULAR / HEART

Arrythmia / Irregular heart beat / palpitation	Yes	No
Dysautonomia / POTS	Yes	Νο
Heart Disease	Yes	Νο
High Blood Pressure	Yes	Νο

Mitral Valve Prolapse	Yes	No
Pacemaker	Yes	No
Syncope / Fainting	Yes	No
Valve Replacement	Yes	No

### NEUROLOGICAL

Cranial Nerve Palsy	Yes	Νο	Migraines	Yes	No
Dizziness	Yes	Νο	Severe Headaches that aren't Migraines	Yes	No
Epilepsy / Seizures	Yes	Νο	Stroke	Yes	No
Feeling Uncoordinated	Yes	Νο	Vertigo	Yes	No

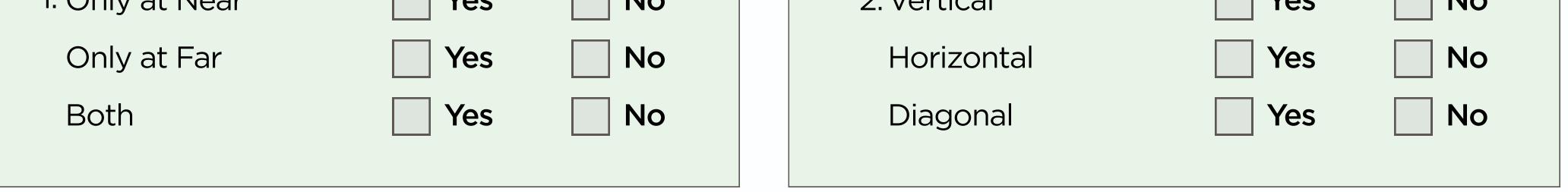
Other:

## DOUBLE VISION



If yes, please answer the below questions:

1 Only at Noar		2 Vortical	



## EARS, NOSE AND THROAT

Benign Positional Vertigo / No Yes BPV / BPPV Fullness Left ear Yes No Fullness Right ear Yes No Meniere's Disease Yes No Ringing / Tinnitus in Left ear Yes No Ringing / Tinnitus in Right ear Yes No

Sensation of fluid leaking from Left ear	Yes	Νο
Sensation of fluid leaking from Right ear	Yes	Νο
Sinus Disorders	Yes	No
Sinus Pain / Pressure	Yes	Νο
Sleep Apnea	Yes	No
TMJ problem	Yes	No

Other:

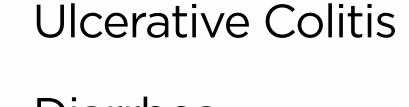
## **RESPIRATORY / LUNGS:**



Other:

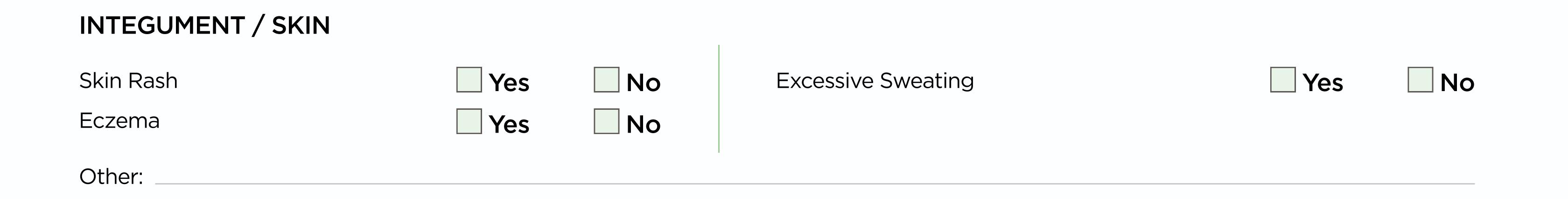
#### **STOMACH / INTESTINES:**

Crohn's Disease	Yes	No
Irritable Bowel Syndrome	Yes	Νο
Nausea	Yes	Νο



Diarrhea

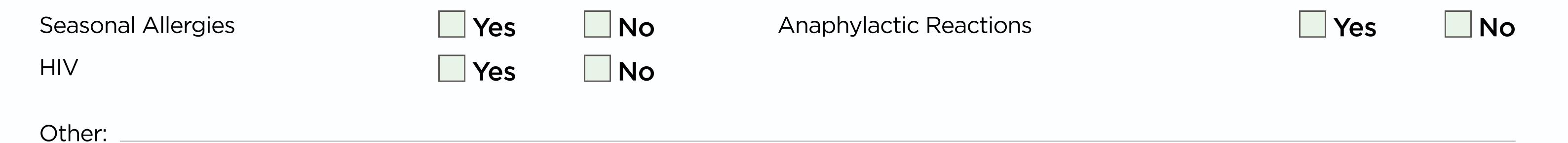




## BONES / JOINTS / MUSCLES

Rheumatoid Arthritis	Yes	Νο	Cerebral Palsy	Yes	No
Polymyalgia	Yes	Νο	Neck Pain	Yes	No
Multiple Sclerosis	Yes	Νο	C-spine Fracture	Yes	No
Fibromyalgia	Yes	Νο	C-spine Fusion	Yes	No

#### ALLERGIC / IMMUNOLOGIC



## PSYCHIATRIC

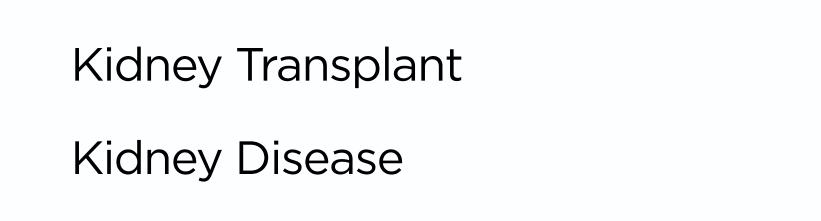
Depression	Yes	Νο	Anx
Panic episodes	Yes	Νο	Ago
PTSD (Post Traumatic Stress Disorder)	Yes	Νο	ADI Atte

Anxiety	Yes	No
Agoraphobia	Yes	Νο
ADD / ADHD (Attention Deficit Disorder/ Attention Deficit Hyperactivity Disorder)	Yes	Νο

Other:

## GENITALS / KIDNEY / BLADDER

Frequent Urination	Yes	No	
Kidney Stones	Yes	Νο	
Dialysis	Vas	No	







Yes



Dialysis	<b>Yes</b>	

	トレ		
0	U	Ie	Ι.

## CONSTITUTION

Fatigue	Yes	No	Chills	Yes	No
Fever	Yes	Νο	Insomnia	Yes	No
Other:					
History of Cancer	Yes	Νο			
If YES, list what kind(s):					



Are you or have you been a smoker?

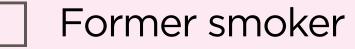
Yes No

Check one:



Current every day smoker

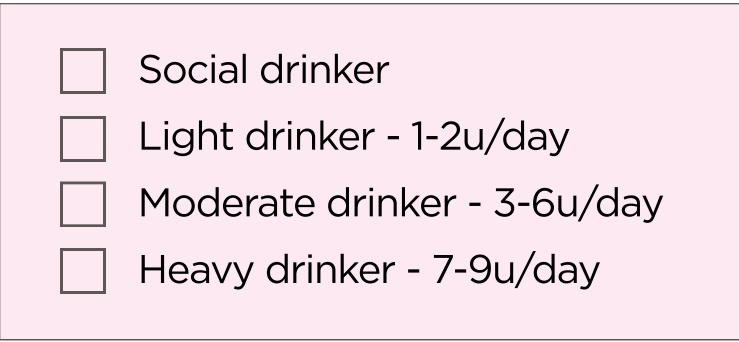
Current some day smoker



Do you drink alcohol?



#### Check one:



## Do you misuse/abuse drugs or medications?



Check all that apply:

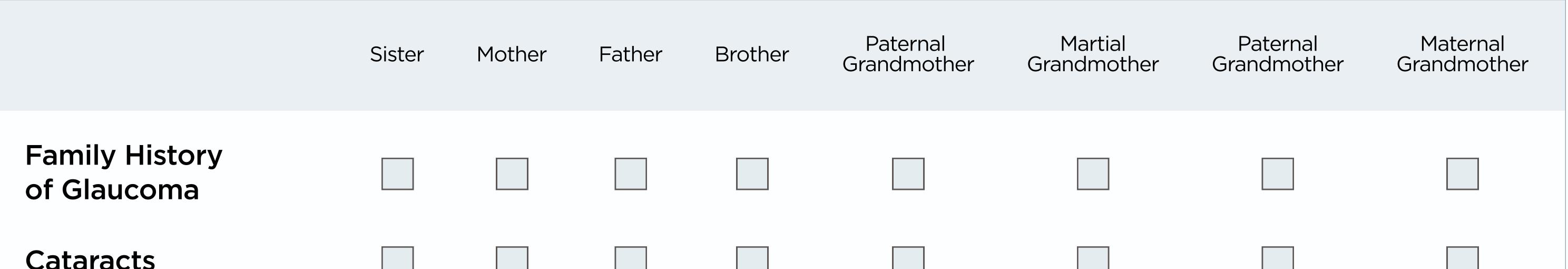
Recreational drug user	Crack	Methamphetamine
Cannabis	- Heroin	Oxycontin
Cocaine	LSD	Speed

## Occupation or Grade in school

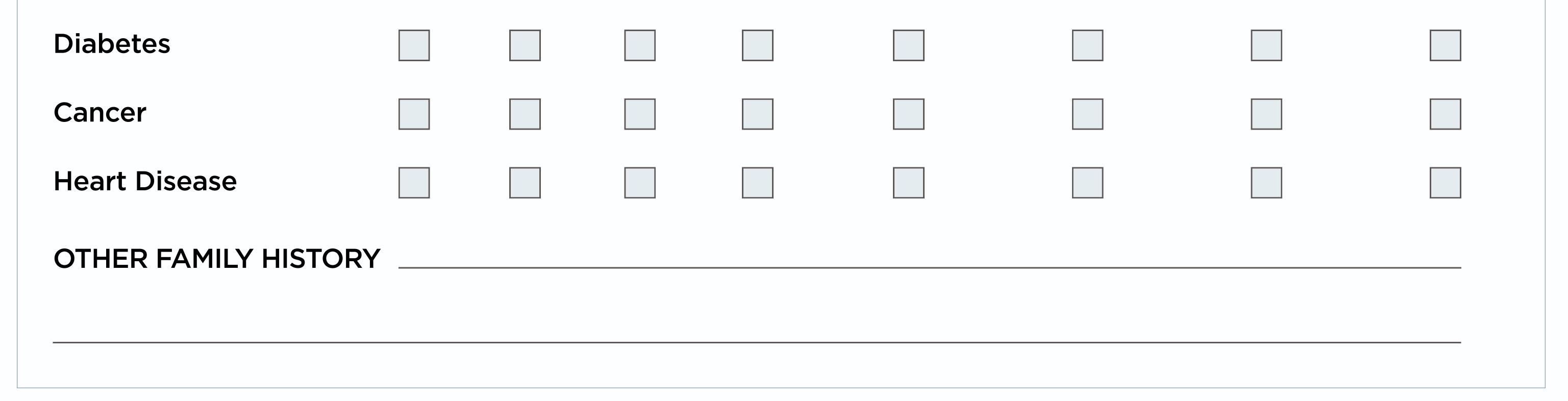
Hobbies



## DO ANY OF YOUR FAMILY MEMBERS HAVE ANY OF THE CONDITIONS LISTED BELOW? IF YES, CHECK ALL THAT APPLY:



Catalacts				
Macular Degeneration				
Eye Injury				
Retina Disease				
Other Eye Disease				
Strabismus				
Amblyopia				
Blindness/ Vision Loss				





Choose the appropriate age

I am 13 years old or younger

I am 14 years old or older