Name: ____ Date: _____________________

E-Mail Address _______________________________________

Would you like to have the Optomap today? (refer to laminated form) ◯ No ◯ Yes ◯ discuss with the doctor

Who is your primary Care Physician (Name, address, and phone number if possible)

____

What is your current**:** **Height** ___________ **Weight** ___________

Social History

Do you drink alcohol? ◯ No ◯ Occasional ◯ 1 Per Day ◯ 2-3 Per Day ◯ 4+ Per Day

Do you smoke? ◯ No ◯ Occasional ◯ ½ Pack/Day ◯ 1 Pack/Day ◯ 1+ Pack/Day

Past smoker ◯ No ◯ Yes When did you quit smoking? __________________________

Do you chew tobacco? ◯ No ◯ Yes

Do you use nutritional supplements? ◯ No ◯ Yes

Do you engage in regular exercise? ◯ No ◯ Yes

Contact Lens History

If you are not a contact lens wearer, are you interested in trying contacts at this time? ◯ No ◯ Yes

Medication

List any drug allergies: ____

List allergic reaction: ____

List current medications/dosage:

____

____

Past surgeries/dates/surgeon:

____

Eye Disease

- ◯ Amblyopia (lazy eye)
- ◯ Blepharitis
- ◯ Blindness
- ◯ Cataract
- ◯ Color Blindness
- ◯ Diabetic Retinopathy
- ◯ Dry Eye Syndrome
- ◯ Eye Injuries
- ◯ Glaucoma
- ◯ Glaucoma Suspect
- ◯ High Risk Medication
- ◯ Macular Degeneration
- ◯ PVD
- ◯ Retinal Detachment
- ◯ Strabismus (eye turn)
- ◯ Other

Current Eye Symptoms

- ◯ Glare Sensitivity
- ◯ Headaches
- ◯ Light Sensitivity
- ◯ Tired Eyes
- ◯ Burning
- ◯ Dryness
- ◯ Epiphora
- ◯ Eyelid Swelling
- ◯ Eye Pain/Soreness
- ◯ Foreign Body Sensation
- ◯ Infection of Eye Lid
- ◯ Itching
- ◯ Mucus
- ◯ Ptosis (drooping eyelid)
- ◯ Redness
- ◯ Sandy or Gritty Feeling
- ◯ Other

Visual Symptoms

- ◯ Blurred Vision Distance
- ◯ Blurred Vision Near
- ◯ Distorted Vision
- ◯ Double Vision
- ◯ Flashes of Light
- ◯ Floaters or Spots
- ◯ Fluctuating Vision
- ◯ Loss of Central Vision
- ◯ Loss of Side Vision
- ◯ Loss of Vision
- ◯ Other

List any new health issues: ____

List any new family health issues: ____