SHIPLEY & WAYLAND

EYECARE

PLEASE PRESENT ALL VISION AND MAJOR MEDICAL INFORMATION TO RECEPTIONIST

DATE: _____

PATIENT'S FIRST AND LAST NAME: _____

DOB: _____/_____/_____ Circle: Male / Female

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

Please circle your preferred method of communication: PHONE CALL TEXT MESSAGE EMAIL

PLEASE CHECK THE REASON FOR TODAY'S VISIT.

☐ Routine Eye Exam ☐ Post-Op Cataract: Right Eye / Left Eye ☐ Other

PLEASE CHECK ALL THAT APPLY TO TODAY'S VISIT.

- ☐ EXAM FOR GLASSES
- ☐ EXAM FOR CONTACT LENSES
- ☐ BLURRED VISION AT DISTANCE
- ☐ BLURRED VISION AT NEAR
- ☐ EYE PAIN
- ☐ ITCHY EYES
- ☐ DRY EYES
- ☐ RED EYES
- ☐ TEARING
- ☐ FLASHES OF LIGHT
- ☐ EYELID SWELLING
- ☐ INGROWN EYELASH
- ☐ FLOATERS
- ☐ DOUBLE VISION
- ☐ DROOPING LIDS
- ☐ HEADACHES / MIGRAINES
- ☐ IRRITATION
- ☐ SWELLING IN EYELIDS
- ☐ LOSS OF VISION

IF BOTH EYES ARE AFFECTED, IS ONE EYE WORSE THAN THE OTHER?

- ☐ Left eye is worse than right eye
- ☐ Right eye and left eye are equal
- ☐ Right eye worse than left eye

How many hours per day do you use a computer? _____

Do you currently wear glasses? ☐ YES ☐ NO

Do you currently wear contact lenses? ☐ YES ☐ NO

If no, are you interested in contact lenses? ☐ YES ☐ NO

Are you interested in refractive (LASIK) surgery? ☐ YES ☐ NO

Do you perform fine or close-up work? ☐ YES ☐ NO

Are you outdoors all or part of the time? ☐ YES ☐ NO

Do you have trouble reading signs when driving at night? ☐ YES ☐ NO

Are you bothered by glare from any of the following?

- ☐ Overhead lighting
- ☐ Computer screen
- ☐ Oncoming headlights at night

MISCELLANEOUS: Are you currently pregnant or nursing? ☐ YES ☐ NO

SOCIAL HISTORY

Are you a drug user? ☐ YES ☐ NO

Are you a: ☐ non-drinker ☐ social drinker

TOBACCO USE

- ☐ Heavy tobacco smoker ☐ Former smoker
- ☐ Light tobacco smoker ☐ Never a smoker

Please Complete Both Sides of the Form **OVER →**

OCULAR HISTORY

Check the box if your answer is YES. Circle if it applies to right eye or left eye.

- ☐ ALLERGIC CONJUNCTIVITIS
- ☐ BLEPHARITIS
- ☐ CATARACT (RIGHT EYE / LEFT EYE)
- ☐ CORNEAL DYSTROPHY (RIGHT EYE / LEFT EYE)
- ☐ DIABETIC RETINOPATHY, Background (RIGHT EYE / LEFT EYE)
- ☐ DIABETIC RETINOPATHY, Proliferative (RIGHT EYE / LEFT EYE)
- ☐ DRY EYES
- ☐ GLAUCOMA (RIGHT EYE / LEFT EYE)
- ☐ MACULAR DEGENERATION (RIGHT EYE / LEFT EYE)
- ☐ MACULAR ERM (RIGHT EYE / LEFT EYE)
- ☐ NARROW ANGLES (RIGHT EYE / LEFT EYE)
- ☐ OCULAR HYPERTENSION (RIGHT EYE / LEFT EYE)
- ☐ OPHTHALMIC/OCULAR MIGRAINE
- ☐ RETINAL TEAR (RIGHT EYE / LEFT EYE)
- ☐ STRABISMUS (cross eyes)
- ☐ PVD (RIGHT EYE / LEFT EYE)
- ☐ VITREOUS FLOATERS (RIGHT EYE / LEFT EYE)
- ☐ OTHER: _____

OCULAR SURGERY

Check the box if your answer is YES. Circle if it applies to right or left eye. List the date of surgery.

- ☐ BLEPHAROPLASTY (RIGHT EYE / LEFT EYE)
  Date of surgery: _____
- ☐ CATARACT SURGERY (RIGHT EYE / LEFT EYE)
  Date of surgery: _____
- ☐ CORNEAL TRANSPLANT(RIGHT EYE / LEFT EYE)
  Date of surgery: _____
- ☐ EYE MUSCLE SURGERY
  Date of surgery: _____
- ☐ LASIK (RIGHT EYE / LEFT EYE)
  Date of surgery: _____
- ☐ STRABISMUS SURGERY
  Date of surgery: _____
- ☐ RETINAL LASER (RIGHT EYE / LEFT EYE)
  Date of surgery: _____
- ☐ OTHER: _____
  Date of surgery: _____

PAST MEDICAL HISTORY

Check any of the following medical conditions that you currently have.

- ☐ ALLERGIES
- ☐ ANXIETY / DEPRESSION
- ☐ ARTHRITIS
- ☐ ASTHMA
- ☐ CARDIOVASCULAR DISEASE
- ☐ DIABETES
- ☐ HYPERCHOLESTEROLEMIA
- ☐ HYPERTENSION (HIGH BLOOD PRESSURE)
- ☐ HYPERTHYROIDISM
- ☐ HYPOTHYROIDISM
- ☐ MIGRAINES
- ☐ RADIATION TREATMENT
- ☐ SEIZURES
- ☐ STROKE
- ☐ THYROID ABNORMALTIES
- ☐ WEIGHT LOSS

FAMILY HEALTH HISTORY

Check the box to each entry that applies. List which family member including mother, father, brother, sister, maternal/paternal grandmother or grandfather.

- ☐ LAZY EYE _____
- ☐ BLINDNESS _____
- ☐ CATARACT _____
- ☐ MACULAR DEGENERATION _____
- ☐ GLAUCOMA _____
- ☐ RETINAL DISORDER _____
- ☐ STRABISMUS (CROSS EYES) _____
- ☐ ARTHRITIS _____
- ☐ CANCER _____
- ☐ DIABETES _____
- ☐ HYPERTENSION (HIGH BLOOD PRESSURE) _____
- ☐ CARDIOVASCULAR DISEASE _____
- ☐ STROKE _____

MEDICATIONS

List all <u>current</u> prescriptions, over-the-counter prescriptions, eye drops, and dosages for each.

_____

_____

_____

_____

MEDICATION <u>ALLERGIES</u>

List any allergies you may have and reaction.

_____

_____

_____

_____

SURGERIES

List any previous surgeries with dates.

_____

_____

_____

_____