SHARP VISION

General Patient's Information **Date**: ___/____/___

Mr./Mrs./Miss/Ms./Dr. Last Name:_____ First Name:_____MI:_____

DOB: ___/___/___ SSN (optional- insurance purpose):_____ Marital Status: Married /Single/Divorced

Address: _____ City:_____ State: _____ Zip:_____

Best phone # to contact you at:_____ Additional phone #: _____

What is your preferred contact method (circle one): email phone

Employer/School:_____Occupation/School Grade:_____

Email Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation:_____ Phone #: _____

Who may we thank for referring you to our office?_____

If not referred, how did you choose our office? (Circle best choice)

Insurance List **Sign/Building** **Newspaper/TV** **Yellow Pages** **Web Page** **Other:**_____

CASE HISTORY/REASON FOR VISIT

Date of Last Medical Exam: ___/___/___ Primary Physician/Clinic: _____

Date of Last Eye Exam: ___/___/___ Clinic/Eye Doctor's Name:_____

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes / No Type _____ Solution Used: _____

Wearing Schedule: **Daily** **Overnight** Replacement Schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had eye injuries? Yes No Which Eye?_____ If yes, when? _____
Have you ever had eye surgeries? Yes No Why? _____ If yes, when? _____
Have you used eye medication? Yes No Why?_____How Often? _____
Are you currently pregnant or nursing? Yes No N/A

Do you…… (Check box if your answer is "Yes")

☐ Work at a computer? How many hours: _____	☐ Have sunglasses? ☐ Prescription ☐ Non-prescription
☐ Think you might benefit from thinner, lighter lenses?	☐ Prefer not to wear your glasses at times?
☐ Have interest in trying the latest contact lens designs	☐ Want information on Laser Vision Correction surgery?
☐ Spend time outdoors? How much? Hrs/week _____	☐ Have visual difficulty when driving?
☐ Have trouble with night driving	☐ Participate in sports activities?
☐ Do you like fishing?	☐ Have more than 1 pair of current Rx eyewear?

WHAT ARE YOUR VISUAL SYMPTOMS? PLEASE CHECK MARK SYMPTOMS THAT APPLIES (specify with or without eyewear):

[ ]Blurred Vision/Distance	[ ]Burning Eyes	[ ]Floaters or Spots	[ ]Crossed Eyes
[ ]Blurred Vision/Near	[ ]Itchy Eyes	[ ]See Flashes	[ ]Light Sensitive
[ ]Double Vision	[ ]Dry Eyes	[ ]See Halos	[ ]Sandy/Gritty Feeling
[ ]Eye Strain	[ ]Red Eyes	[ ]Poor Night Vision	[ ]Poor Color Vision
[ ]Eye Infections	[ ]Watery Eyes	[ ]Headaches	[ ]Droopy Lid
[ ]Eye Pain/Soreness	[ ]Wandering Eye	[ ]Migraine Headaches	
[ ]Tired Eyes	[ ]Mucus Discharge	[ ]Loss of Vision	

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.

Cardiovascular: ____None ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	**Endocrine:** ____None ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Problem ___Hormonal Dysfunction ___Other:	**Respiratory:** ____None ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional: ____None ___Cancer ___Trauma/Large Volume Blood Loss ___Developmental Disability ___Other:	**Ocular:** ____None ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	**Psychiatric:** ____None ___ADHD ___Depression ___Schizophrenia ___Other:
Neurological: ____None ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	**Musculoskeletal:** ____None ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	**Immunologic:** ____None ___AIDS or HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other
Hematological: ____None ___Anemia ___Leukemia ___Other:	**Gastrointestinal:** ____None ___Crohn's ___Colitis ___Weight Loss/Increase	**Ear/Nose/Throat:** ____None ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic: ____None ___Eczema ___Rosacea ___Psoriasis ___Other:	**Allergies:** (Please List) ____None Drug: Reaction: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list any medications that you are taking (including herbal):

1. _____ For _____
2. _____ For _____
3. _____ For _____
4. _____ For _____
5. _____ For _____
6. _____ For _____

FAMILY HISTORY: Has anyone in your family (Grandparents, Parents, Siblings, Etc) been diagnosed with:

DISEASE/CONDITION

Retinal Detachment:	Yes/No _____	Blindness:	Yes/No _____
High Blood Pressure	Yes/No _____	Cataracts:	Yes/No _____
Diabetes:	Yes/No _____	Glaucoma:	Yes/No _____
Cancer:	Yes/No _____	Crossed Eyes:	Yes/No _____
Heart Disease:	Yes/No _____	Macular Degeneration:	Yes/No _____
Thyroid Disease:	Yes/No _____	Lupus:	Yes/No _____

Doctor's Signature: _____ Date: _____