joey's optical

Exam Date_____
Name _____ **Birthdate** _____**Age**_____
Email address _____
***SSN ONLY if Medicare or Veteran billing**_____-_____-_____
Occupation_____
Previous Eye Doctor_____ **Last Eye Exam**_____
Age of current eyeglasses _____
Have you had refractive (cataract/Lasik) surgery? Y/N If so, date and type _____
Do you wear contact lenses? Y/N How often do you replace them? _____
Are you having any visual difficulties? _____

Are you currently experiencing any of the following problems with your eyes? Circle only if "yes".

Blurred Vision	Flashers/Floaters	Redness
Loss of vision	Halos/Glare/Light sensitivity	Excess tearing
Double vision	Dryness	Eye pain or soreness
Tired eyes	Sandy/gritty feeling	Mucus discharge
Burning/itching	Inflammation of the eyelid/styes	

_____
_____

Have YOU been diagnosed with any of the following eye problems? Circle only if "yes".

Cataracts	Retinal Detachment/Disease	Crossed Eyes
Lazy Eye/Amblyopia	Dry Eye	Eye Injury
Macular Degeneration	Glaucoma	Other

Please explain _____
_____

FOR OFFICE USE ONLY:

Vision Insurance_____**Exam copay**_____ ***Must have SSN for Medicare or VA Insurance**

Color: _____ P/F

Presenting Rx:

OD _____

OS _____

Add _____

Type_____

Contact Lens Rx:

OD _____

Type, BC/Dia _____

OS _____

Type, BC/Dia _____

PERSONAL MEDICAL HISTORY

List any medications you are currently taking (including oral contraceptives, aspirin and over the counter medications) *or provide a medication list*_____

_____

Are you allergic to any medications? Y/N Please list _____

List all major surgeries and/or hospitalizations you have had _____

_____

_____

Primary Care Physician _____Facility/Location_____Last Medical Exam _____

Review of systems – Please circle any problems you have or have had in the past:

Allergy/Immunologic
- Allergy/Hay Fever

Cardiovascular/Cardiac
- Arteriosclerosis
- Heart Disease
- High Blood Pressure
- Cholesterol

Constitutional
- Weight Loss
- Fever

Ears, Nose, Mouth, Throat
- Dry throat/mouth
- Sinus Congestion

Endocrine
- Diabetes
- Thyroid Disease
- Chronic Fatigue

Gastrointestinal
- Diarrhea/Constipation
- IBS/Crohn's Disease
- Ulcers
- Reflux

Genitourinary
- Kidney Disease
- Ovarian/Uterine Cancer
- Prostate Cancer

Hematologic/Lymphatic
- Anemia
- Breast Cancer
- Bleeding Problems

Integumentary (skin)
- Cancer
- Rashes
- Easy Bruising

Musculoskeletal
- Rheumatoid Arthritis
- Joint/Muscle pain

Neurological
- Migraines
- Dizziness
- Seizures
- Stroke

Psychiatric
- Anxiety
- Depression
- Memory Loss
- Hallucinations

Respiratory
- Asthma
- Bronchitis
- Emphysema
- Chronic Cough

If you have a condition that is not listed, please list here: _____

Are you pregnant or nursing Y/N or NA

FAMILY HISTORY: (parents, grandparents, siblings, children: living or deceased)

Relationship to you	**Relationship to you**
Glaucoma _____	Diabetes _____
Cataract _____	Cancer _____
Macular Degeneration _____	Heart Disease _____
Retinal Detachment _____	High Blood Pressure _____
Blindness _____	Kidney Disease _____
Crossed eyes _____	Lupus/Arthritis _____