Horner Family Eyecare

General Information

Date

Last Name | First Name | M | DOB

M or F ○ Male ○ Female | Last 4 digits of SSN | Marital Status : ○ Married ○ Single ○ Divorced

Address | City | State | Zip

Home Phone | Work Phone | Cell Phone

Employer / School | Occupation / School Grade

E-mail Address | Sports / Hobbies

Emergency Contact | Relation | Phone #

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

Do you wear contacts? ○ Yes ○ No Type

Have you ever had eye injuries? ○ Yes ○ No Which Eye?

Have you ever had eye surgeries? ○ Yes ○ No Why?

Have you used eye medication? ○ Yes ○ No Why?

Are you currently pregnant or nursing? ○ Yes ○ No ○ N/A

Have you ever been diagnosed with?

Cataracts ○ Yes ○ No When were you diagnosed?

Glaucoma ○ Yes ○ No When were you diagnosed?

Macular Degeneration ○ Yes ○ No When were you diagnosed?

What are your visual symptoms: Please circle any that apply:

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

Notes

Confidential

please turn over and complete other side

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:

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Other
- ☐ None

Endocrine:

- ☐ Non-Insulin Dependent Diabetes
- ☐ Stroke
- ☐ Thyroid Problem
- ☐ Hormonal Dysfunction
- ☐ Other
- ☐ None

Respiratory:

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ COPD
- ☐ Other
- ☐ None

Constitutional:

- ☐ Cancer
- ☐ Trauma/Large Volume Blood Loss
- ☐ Developmental Disability
- ☐ Other
- ☐ None

Ocular:

- ☐ Glaucoma
- ☐ Macular Degeneration.
- ☐ Detached Retina
- ☐ Other
- ☐ None

Psychiatric:

- ☐ ADHO
- ☐ Depression
- ☐ Schizophrenia
- ☐ Other
- ☐ None

Neurological:

- ☐ Multple Sclerosis
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Other
- ☐ None

Musculoskeletal:

- ☐ Osteoarthirits
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Other
- ☐ None

Immunologic:

- ☐ AIDS or HIV
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Neurofibromatosis
- ☐ Other
- ☐ None

Hematological:

- ☐ Anemia
- ☐ Leukemia
- ☐ Other
- ☐ None

Gastrointestinal:

- ☐ Crohn's
- ☐ Colitis
- ☐ Other
- ☐ None

Ear/Nose/Throat:

- ☐ Hearing Loss
- ☐ Upper Respiratory Infection
- ☐ Other
- ☐ None

Dermatologic:

- ☐ Eczema
- ☐ Rosacea
- ☐ Posoriasis
- ☐ Other
- ☐ None

Allergies (please list)

- ☐ Drug
- ☐ Environmental
- ☐ None

Alcohol Use:

- ○ Yes
- ○ No

Amount _____

Tobacco Use:

- ○ Yes
- ○ No

Amount _____

Please list physical reactions to above allergies: _____

Please list any medications and/or drugs that you are taking (including herbal) :

1		For		2		For	
3		For		4		For	
5		For		6		For	
7		For		8		For	
9		For		10		For	

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) 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	

Reviewed by:

Dr _____ Date _____