Martin Optical

General Information

Date: _____/______/_______

Last Name__________________________ First Name: _______________M _______DOB: ____/____/____

M or F SSN: _______ / _____ / ________ Marital Status: Married / Single / Divorced

Address: _________________________________ City: ____________________ State: _______ Zip: ________

Home Ph: ( ) ________________ Work Ph: ( ) _________________ Cell Ph: ( ) ________________

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

How old are your present glasses: _________________________ Do you wear perscription Sun Wear: Yes/No

Do you wear contacts? Yes No Type:_____________________ Solution Used: _______________________

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

If you do not wear contacts, are you interested in getting them? Yes No

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?_______________________________________

<u>What are your visual symptoms: Please circle any that apply:</u>

[ ] Blurred Vision/Distance
[ ] Blurred Vision/Near
[ ] Double Vision
[ ] Eye Strain
[ ] Eye Infections
[ ] Eye Pain/Soreness
[ ] Tired eyes
[ ] Burning Eyes
[ ] Itchy Eyes

[ ] Dry Eyes
[ ] Red Eyes
[ ] Watery Eyes
[ ] Wandering eye
[ ] Mucus Discharge
[ ] Floaters or Spots
[ ] See Flashes
[ ] See Halos
[ ] Poor Night Vision

[ ] Headaches
[ ] Migraine Headaches
[ ] Loss of Vision
[ ] Crossed Eyes
[ ] Light Sensitive
[ ] Sandy/Gritty Feeling
[ ] Poor Color Vision
[ ] Droopy Lid

How did you hear about our office? ________________________________ Are you interested in LASIK? Yes/No

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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: __ **None**	**Endocrine:** ___ **None**	**Respiratory:** __ **None**
___ Hypertension	___ Non-Insulin Dependent Diabetes	___ Asthma
___ Stroke	___ Insulin Dependent Diabetes	___ Bronchitis
___ Heart Disease	___ Thyroid Problem	___ Emphysema
___ Vascular Disease	___ Hormonal Dysfunction	___ COPD
___ Other:	___ Other:	___ Other:
Constitutional: __ **None**	**Ocular** __ **None**	**Psychiatric:** __ **None**
___ Cancer	___ Glaucoma	___ ADHD
___ Trauma/Large Volume Blood Loss	___Macular Degeneration	___ Depression
___ Developmental Disability	___Detached Retina	___ Schizophrenia
___ Other:	___ Other:	___ Other:
Neurological: __ **None**	**Musculoskeletal:** __ **None**	**Immunologic:** __ **None**
___ Multiple Sclerosis	___ Osteoarthritis	___ AIDS or HIV
___ Epilepsy	___ Fibromyalgia	___ Rheumatoid Arthritis
___ Cerebral Palsy	___ Muscular Dystrophy	___ Lupus
___ Tumor	___ Ankylosing Spondylitis	___ Neurofibromatosis
___ Other:	___ Other:	___ Other:
Hematological: __ **None**	**Gastrointestinal** __ **None**	**Ear/Nose/Throat:** __ **None**
___ Anemia	___ Crohn's	___ Hearing Loss
___ Leukemia	___ Colitis	___ Upper Respiratory Infection
___ Other:	___ Other:	___ Other:
Dermatologic: __ **None**	**Allergies** (please list) __ **None**	
___ Eczema	Drug:	**Alcohol Use:** **Y** **N**
___ Rosacea		Amount:
___ Psoriasis		
___ Other:	Environmental:	**Tobacco Use:** **Y** **N**
		Amount:

Please list physical reaction's 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 Degeneratior	Yes/No	________
Thyroid Disease:	Yes/No	________	Lupus	Yes/No	________

Reviewed by:

Dr ______________________________ Date ______________________________

Revised 10/06

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