LANSDOWNE EYE ASSOCIATES

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NAME ______________________ DATE ____________ DOB ____________

ADDRESS ______________________________

CITY ______________ STATE ______ ZIP CODE __________ EMAIL ____________

CELL # ____________ WORK # ____________ HOME # ____________

SEX ☐ MALE ☐ FEMALE LAST 4 OF SS# ________

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ OTHER ☐ CHILD ☐ FULL TIME STUDENT

MEDICAL INSURANCE ______________ VISION INSURANCE ______________

PERSON RESPONSIBLE FOR PAYMENT ______________

PRIMARY CARE PHYSICIAN ______________ PCP EMAIL ______________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE ______________

DATE OF LAST OCULAR EVALUATION ____________ DOCTOR ____________

DO YOU CURRENTLY WEAR GLASSES ☐ YES ☐ NO DO YOU USE A COMPUTER ☐ YES ☐ NO HOW MANY HOURS A DAY ______

DO YOU CURRENTLY WEAR CONTACTS ☐ NO ☐ YES ☐ SOFT ☐ DAILY ☐ EXTENDED ☐ DISPOSABLE ☐ RGP

HOW LONG DO YOU WEAR EACH PAIR ____________ HOW OLD IS YOUR CURRENT PAIR ____________

WHAT IS YOUR MAIN VISUAL COMPLAINT / REASON FOR TODAY'S VISIT ______________________

____

PLACE A MARK ON "YES" OR "NO" TO INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

	yes	no		yes	no		yes	no
BLURRED VISION	☐	☐	EYE INJURIES	☐	☐	LOSS OF VISION	☐	☐
BURNING	☐	☐	EYE STRAIN	☐	☐	MIGRAINE	☐	☐
CATARACTS	☐	☐	FAINTING	☐	☐	NIGHT VISION, POOR	☐	☐
COLOR DEFECT	☐	☐	FLASHES OF LIGHT	☐	☐	VISION LOSS, TEMPORARY	☐	☐
CROSSED EYES	☐	☐	FLOATERS OR SPOTS	☐	☐	TWITCHING OF EYES	☐	☐
DISCHARGE	☐	☐	GLAUCOMA	☐	☐	WATERY DISCHARGE	☐	☐
DIZZY SPELLS	☐	☐	HEADACHES	☐	☐	DIZZY SPELLS	☐	☐
DOUBLE VISION	☐	☐	HALOS AROUND LIGHTS	☐	☐	DOUBLE VISION	☐	☐
DRY EYES	☐	☐	ITCHING	☐	☐	DRY EYES	☐	☐
EYE INFECTIONS	☐	☐	LIGHT SENSITIVITY	☐	☐	EYE INFECTIONS	☐	☐

DESCRIBE ANY OTHER OCULAR PROBLEMS ______________________

____

Personal Medical Information: Do you have any problems with any of the following:

	yes	no		yes	no		yes	no
RESPIRATORY	☐	☐	NEUROLOGICAL	☐	☐	ALLERGY/IMMUNOLOGIC	☐	☐
ASTHMA	☐	☐	HEADACHES	☐	☐	SKIN DISEASE / RASHES	☐	☐
CARDIOVASCULAR	☐	☐	MIGRAINE	☐	☐	MENTAL ILLNESS	☐	☐
HYPERTENSION	☐	☐	ENDOCRINE	☐	☐	EAR/NOSE/THROAT	☐	☐
GASTROINTESTINAL	☐	☐	DIABETES	☐	☐	GENITOURINARY	☐	☐
MUSCULOSKELETAL	☐	☐	BLOOD/LYMPHATIC	☐	☐	SURGERIES	☐	☐
ARTHRITIS	☐	☐	CANCER	☐	☐	TYPE ____________		

Family Medical Information: Do you have a family history of any of the following:

	yes	no		yes	no		yes	no
DIABETES	☐	☐	GLAUCOMA	☐	☐	HIGH BLOOD PRESSURE	☐	☐
MACULAR DEGENERATION	☐	☐	RETINAL DETACHMENT	☐	☐	CATARACTS	☐	☐

please explain any boxes you have checked ____

____

TOBACCO USE ☐ YES ☐ NO ☐ QUIT

ALCOHOL USE ☐ SOCIAL ☐ NONE ☐ 1-2 / DAY ☐ 3+ / DAY

IF YES, HOW MUCH? ________ PACKS/DAY

MEDICATION HISTORY

MEDICATIONS: ____

OVER-THE-COUNTER ____

HERBALS: ____

EYE MEDS (DROPS): ____

ALLERGIES TO MEDS ____

PHARMACY ____

additional comments:

____

____

____

____

____

please sign below that you have reviewed all of the information and that it is correct to the best of you knowledge.

SIGNATURE ____ DATE ____________________