

# Bieter Eye Center

## General Information

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last Name \_\_\_\_\_ First Name: \_\_\_\_\_ M \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_  
M or F \_\_\_\_\_ SSN: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Marital Status: Married / Single / Divorced / Widowed  
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 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? \_\_\_\_\_

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:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

<input type="checkbox"/> Blurred Vision/Distance	R L B	<input type="checkbox"/> Dry Eyes	R L B	<input type="checkbox"/> Headaches	R L B
<input type="checkbox"/> Blurred Vision/Near	R L B	<input type="checkbox"/> Red Eyes	R L B	<input type="checkbox"/> Migraine Headaches	R L B
<input type="checkbox"/> Double Vision	R L B	<input type="checkbox"/> Watery Eyes	R L B	<input type="checkbox"/> Loss of Vision	R L B
<input type="checkbox"/> Eye Strain	R L B	<input type="checkbox"/> Wandering eye	R L B	<input type="checkbox"/> Crossed Eyes	R L B
<input type="checkbox"/> Eye Infections	R L B	<input type="checkbox"/> Mucus Discharge	R L B	<input type="checkbox"/> Light Sensitive	R L B
<input type="checkbox"/> Eye Pain/Soreness	R L B	<input type="checkbox"/> Floaters or Spots	R L B	<input type="checkbox"/> Sandy/Gritty Feeling	R L B
<input type="checkbox"/> Tired eyes	R L B	<input type="checkbox"/> See Flashes	R L B	<input type="checkbox"/> Poor Color Vision	R L B
<input type="checkbox"/> Burning Eyes	R L B	<input type="checkbox"/> See Halos	R L B	<input type="checkbox"/> Droopy Lid	R L B
<input type="checkbox"/> Itchy Eyes	R L B	<input type="checkbox"/> Poor Night Vision	R L B		

\*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.**

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

Please list physical reaction's to above allergies: \_\_\_\_\_

Please list any medications and/or drugs that you are taking (including herbal) : \_\_\_\_\_ See Attached List: \_\_\_\_\_

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

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

**DISEASE / CONDITION**

Lupus: 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 Degenerati <sup>o</sup> r Yes/No _____
Thyroid Disease: Yes/No _____	Retinal Detachment <sup>1</sup> Yes/No _____

Reviewed by:

Dr \_\_\_\_\_ Date \_\_\_\_\_