Dakota Eye Care

General Information

Date: _____/_____/_____

Last Name_____ First Name: _____M _____DOB: ____/____/____

M or F SSN: _____ / _____ / _____ Married / Single / Divorced / Domestic Partner

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: ( ) _____ Work Ph: ( ) _____ Cell Ph: ( ) _____

Employer/School:_____ FT PT Occupation:_____

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 Full Time Reading only Driving only

Do you routinely wear sunglasses? Yes No Do you wear contact lenses?: Yes Nc

Are you interested in being fit with contact lenses? 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?_____

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

[ ] Blurred Vision/Distance
[ ] Blurred Vision/Near
[ ] Double Vision
[ ] Eye Strain or Tired Eyes
[ ] Eye Infections
[ ] Eye Pain/Soreness
[ ] Poor night vision
[ ] Burning Eyes or Itchy eyes
[ ] Dry Eyes
[ ] Red Eyes
[ ] Watery Eyes
[ ] Wandering eye / crossed eye
[ ] Mucus Discharge
[ ] Floaters or Spots
[ ] See Flashes
[ ] Headaches
[ ] Droopy Eyelid
[ ] Loss of Vision
[ ] Light Sensitive
[ ] Sandy/Gritty Feeling

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
___High Cholesterol	___ 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 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	

Date:_____ **Patient Sign:**_____ **Dr. review:**_____**Date:**_____

Date:_____ Patient Sign: _____ Dr. Review:_____Date:_____

Date:_____ Patient Sign: _____ Dr. Review: _____Date:_____