Crossroads Optometric Clinic, Inc.

General Information Date:_____/_____/_____

Last Name_____ First Name_____ M____ DOB ____/____/____

Male or Female Marital Status: Married / Single / Divorced / Widowed

Address_____ City_____State_____ Zip_____

Home #_____ Work #_____ Cell #_____

Email _____ Sports/Hobbies_____

Employer/School_____ Occupations/Grade_____

Emergency Contact_____ Relation_____ Phone #_____

CASE HISTORY

Date of last medical exam____/____/____ Primary Physician/Clinic_____

Date of last eye exam ____/____/____ Clinic/Dr. Name_____

Do you wear glasses Yes No All the time / Sometimes / Work / Reading / Driving

How old are your present glasses_____ Do you wear prescription sunwear_____

Do you wear contacts_____ Contact Solution Used_____

Contacts Replacement Schedule Daily / 2 week / Monthly / Yearly

Have you ever had an eye injury Y N Which eye_____

Have you ever had eye surgery Y N Why_____

Have you used eye medication Y N Why_____

Are you currently nursing/pregnant Y N N/A

Have you ever been diagnosed with:

Cataracts Y N When_____

Glaucoma Y N When_____

Macular Degeneration Y N When_____

Visual Symptoms – Please indicate Right, Left or Both along with severity: 1(low), 2(moderate), 3(High)

[ ]	Blurred vision/distance	R L B	[ ]	Dry eyes	R L B	[ ]	Headaches	R L B
[ ]	Blurred vision/near	R L B	[ ]	Red eyes	R L B	[ ]	Migraines	R L B
[ ]	Double vision	R L B	[ ]	Watery eyes	R L B	[ ]	Loss of vision	R L B
[ ]	Eye strain	R L B	[ ]	Wandering eye	R L B	[ ]	Crossed eyes	R L B
[ ]	Eye infection(s)	R L B	[ ]	Mucus Discharge	R L B	[ ]	Light sensitive	R L B
[ ]	Eye pain/soreness	R L B	[ ]	Floaters/spots	R L B	[ ]	Sandy/gritty feeling	R L B
[ ]	Tired eyes	R L B	[ ]	Flashes	R L B	[ ]	Poor color vision	R L B
[ ]	Burning eyes	R L B	[ ]	Halos	R L B	[ ]	Droopy lid	R L B
[ ]	Itchy eyes	R L B	[ ]	Poor night vision	R L B			

PERSONAL MEDICAL HISTORY: Please check if any of the following applies to you. If none of these apply, please check NONE.

Cardiovascular ___NONE ___Hypertension ___Stroke ___Heart Disease ___Vascular Disease ___Other:	Endocrine ___NONE ___Non-Insulin Dependent Diabetes ___Insulin Dependent Diabetes ___Thyroid Disease ___Hormone Dysfunction ___Other:	Respiratory ___NONE ___Asthma ___Bronchitis ___Emphysema ___COPD ___Other:
Constitutional ___NONE ___Cancer ___Trauma/Large Volume Loss ___Developmental Disability ___Other:	Ocular ___NONE ___Glaucoma ___Macular Degeneration ___Detached Retina ___Other:	Psychiatric ___NONE ___ADHD ___Depression ___Schizophrenia ___Other:
Neurological ___NONE ___Multiple Sclerosis ___Epilepsy ___Cerebral Palsy ___Tumor ___Other:	Musculoskeletal ___NONE ___Osteoarthritis ___Fibromyalgia ___Muscular Dystrophy ___Ankylosing Spondylitis ___Other:	Immunologic ___NONE ___AIDS / HIV ___Rheumatoid Arthritis ___Lupus ___Neurofibromatosis ___Other:
Hematological ___NONE ___Anemia ___Leukemia ___Other:	Gastrointestinal ___NONE ___Crohn's ___Colitis ___Other:	Ear/Nose/Throat ___NONE ___Hearing Loss ___Upper Respiratory Infection ___Other:
Dermatologic ___NONE ___Eczema ___Rosacea ___Psoriasis ___Other:	Allergies ___NONE Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount

Please list physical reactions to the above allergies: _____

_____

_____

List any medications you are currently 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) been diagnosed with the following:

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 Degen.	Yes/No	_____
Thyroid Disease	Yes/No	_____	Lupus	Yes/No	_____

Reviewed by:

Dr _____ Date _____