Alexandria Eye Clinic, P.A.

Date: _____ /_____ /_____

Last Name: ______________________ First Name: ______________________ MI: ______

Preferred Name: ______________________ Birthdate: _____ /_____ /_____ Preferred Language: ______________

Circle **ONE**: Caucasian Hispanic/Latino Indian African American Asian Multiracial

M or F Marital Status: ______________________ Spouse: ______________________

Address: ______________________ City: ______________ State: ________ Zip: ________

Home Ph: ( ) ______________ Work Ph: ( ) ______________ Cell Ph: ( ) ______________

Employer: ______________________ Occupation: ______________________

Email Address: ______________________

Emergency Contact: ______________________

Who referred you to our office? ______________________

Date of Last Medical Exam: _____ /_____ /_____ Primary Physician/Clinic: ______________________

Date of Last Eye Exam: _____ /_____ /_____ Clinic/Eye Doctor's Name: ______________________

Pharmacy: ______________________

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 contacts? Yes - No

Have you ever had any surgery? (tonsillectomy, appendectomy, etc.) ______________________

Have you ever had eye injuries/surgery? ______________________

____

Have you used eye medications? Yes - No Why? ______________________

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? ______________________

Detached Retina: Yes - No When were you diagnosed? ______________________

What are your visual symptoms? Please check any that may apply:

- ☐ No Visual Symptoms
- ☐ 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 Eye
- ☐ Wandering Eye
- ☐ Mucus Discharge
- ☐ Floaters or Spots
- ☐ See Flashes
- ☐ See Halos
- ☐ Poor Night Vision
- ☐ Headaches
- ☐ Problems Driving
- ☐ Migraine Headaches
- ☐ Loss of Vision
- ☐ Crossed Eyes
- ☐ Light Sensitive
- ☐ Sandy/Gritty Feeling
- ☐ Poor Color Vision
- ☐ Droopy Lid

MORE ON OTHER SIDE →

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU. IF YOU HAVE NON OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Constitutional:	**Repirator:**	**Endocrin:**
☐ Cancer ☐ Developmental Disability ☐ Fatigue Syndrome ☐ Dementia/Alzheimer's ☐ Other: ____________ ☐ **None**	☐ Asthma ☐ Sleep Apnea ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other: ____________ ☐ **None**	☐ Type I Diabetes ☐ Type II Diabetes ☐ Thyroid Problems ☐ Hormonal Dysfunction ☐ Other: ____________ ☐ **None**
Ear/Nose/Throat: ☐ Hearing Loss ☐ Sinusitis ☐ Upper Respiratory ☐ Laryngitis ☐ Other: ____________ ☐ **None**	**Gastrointestinal:** ☐ Celiac Disease ☐ Acid Reflux ☐ Crohn's ☐ Colitis ☐ Ulcer ☐ Other: ____________ ☐ **None**	**Genitourinary:** ☐ Kidney Disease ☐ Herpes ☐ Nursing ☐ Pregnant ☐ STD ☐ Chlamydia ☐ Prostate Disease/Cancer ☐ Other: ____________ ☐ **None**
Neurological: ☐ Multiple Sclerosis ☐ Migraine ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other: ____________ ☐ **None**	**Musculoskeletal:** ☐ Osteoarthritis ☐ Osteoporosis ☐ Fibromyalgia ☐ Arthritis ☐ Muscular Dystropy ☐ Gout ☐ Ankylosing Spondylitis ☐ Other: ____________ ☐ **None**	**Hematological/Lymphatic:** ☐ Anemia ☐ Large Volume Blood Loss ☐ High Cholesterol ☐ Ulcer ☐ Other: ____________ ☐ **None**
Psychiatric: ☐ ADHD/ADD ☐ Anxiety ☐ Depression ☐ Schizophrenia ☐ Bipolar ☐ Other: ____________ ☐ **None**	**Dermatologic/Integumentary:** ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Herpes Simplex/Cold Sores ☐ Herpes Zoster/Shingles ☐ Other: ____________ ☐ **None**	**Immune:** ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other: ____________ ☐ **None**
Cardiovascular: ☐ Hypertension (High Blood Pressure) ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ Other: ____________ ☐ **None**	**Are you Allergic to any medications/Drugs?** If so, please list: ☐ **None**	**Do you have any Environmental Allergies?** If so, please list: ☐ **None**

Alcohol Use: Yes - No
Amount:

Tobacco Use: Yes - No
Amount:

Please Circle 1: Former Smoker / Never Smoked / Current Smoke / Smokes Everyday / Smokes Somedays

MEDICATIONS:

1 ____________________ 6 ____________________
2 ____________________ 7 ____________________
3 ____________________ 8 ____________________
4 ____________________ 9 ____________________
5 ____________________ 10 ____________________

Family History: Has anyone in your family (parents, siblings, children, living or deceased) been diagnosed with:

Lupus: Yes - No ____________________
Cancer: Yes - No ____________________
Diabetes: Yes - No ____________________
Cataracts: Yes - No ____________________
Thyroid Disease: Yes - No ____________________
Other: Yes - No ____________________
High Blood Pressure: Yes - No ____________________
Glaucoma: Yes - No ____________________
Crossed Eyes: Yes - No ____________________
Macular Degeneration: Yes - No ____________________
Retinal Detachment: Yes - No ____________________