J.K. LANNIN, O.D.
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Name: Last_____ First_____ MI___ Date: _____
Mailing Address: Street_____ City_____ State___ ZIP_____
Phone: Home_____ Cell_____ Work_____
Email Address: _____ Gender: M___ F____
Social Security No: _____ Date of Birth:_____
Marital Status: Single__ Married__ Divorced__ Widowed__
Height: ___feet ___inches Weight: _____lbs.
Race: American Indian__ Alaska Native__ Asian__ Black/African American__
Native Hawaiian/Pacific Islander__ White/Caucasion__ Native American__
Ethnicity: Hispanic/Latino __Yes __No Preferred Language: _____
Emergency Contact: Name_____ Phone_____
Primary Care Physician: _____
Employer: Name_____ Occupation_____ Phone_____
Medical Insurance: _____ Vision Insurance: _____
Insured's Name: _____ Insured's Date of Birth: _____
Reason for today's visit: _____
Past Surgeries:_____
_____
Major Illnesses: _____
Allergy/Reaction: _____
_____
Medications: _____
_____

Eye History – Diseases

Amblyopia (lazy eye)	**__Yes**	**__No**
Blepharitis (lid infection)	**__Yes**	**__No**
Blindness	**__Yes**	**__No**
Cataract(s)	**__Yes**	**__No**
Color Blindness	**__Yes**	**__No**
Diabetic Retinopathy	**__Yes**	**__No**
Dry Eye Syndrome	**__Yes**	**__No**
Eye Injuries	**__Yes**	**__No**
Glaucoma	**__Yes**	**__No**
Glaucoma Suspect	**__Yes**	**__No**
High Risk Medication	**__Yes**	**__No**
Macular Degeneration	**__Yes**	**__No**
Posterior Vitreous Detachment	**__Yes**	**__No**
Retinal Detachment	**__Yes**	**__No**
Strabismus (Eye Turn)	**__Yes**	**__No**

Current Eye Symptoms

Glare Sensitivity	**__Yes**	**__No**
Headaches	**__Yes**	**__No**
Light Sensitivity	**__Yes**	**__No**
Tired Eyes	**__Yes**	**__No**
Burning	**__Yes**	**__No**
Dryness	**__Yes**	**__No**
Tearing	**__Yes**	**__No**
Eye Lid Swelling	**__Yes**	**__No**
Eye Pain/Soreness	**__Yes**	**__No**
Foreign Body Sensation	**__Yes**	**__No**
Infection of Eyelid	**__Yes**	**__No**
Itching	**__Yes**	**__No**
Mucous	**__Yes**	**__No**
Ptosis(drooping lid)	**__Yes**	**__No**
Redness	**__Yes**	**__No**
Gritty/Sandy Feeling	**__Yes**	**__No**
Blurred Vision Distance	**__Yes**	**__No**
Blurred Vision Near	**__Yes**	**__No**
Distorted Vision	**__Yes**	**__No**
Double Vision	**__Yes**	**__No**
Flashes	**__Yes**	**__No**
Floaters	**__Yes**	**__No**
Fluctuating Vision	**__Yes**	**__No**
Loss of Central Vision	**__Yes**	**__No**
Loss of Side Vision	**__Yes**	**__No**

Review of Systems			Explanation
Constitutional Symptoms (fever, weight loss, etc.)	__Yes	__No	_____
Ears, Nose Throat, Mouth	__Yes	__No	_____
Cardiovascular (heart, hypertension, etc.)	__Yes	__No	_____
Respiratory (asthma, emphysema, etc.)	__Yes	__No	_____
Gastrointestinal	__Yes	__No	_____
Genital, Kidney, Bladder	__Yes	__No	_____
Muscles, Bones, Joints (arthritis, etc.)	__Yes	__No	_____
Skin, (rash, itching, skin cancer, etc.)	__Yes	__No	_____
Neurological, (multiple sclerosis, etc.)	__Yes	__No	_____
Psychiatric, (anxiety, depression, etc.)	__Yes	__No	_____
Endocrine, (diabetic, hypothyroid, etc.)	__Yes	__No	_____
Blood, Lymph, (anemia, cholesterol, etc.)	__Yes	__No	_____
Allergic, Immunologic, (seasonal, lupus, etc.)	__Yes	__No	_____
Pregnant	__Yes	__No	_____
Nursing	__Yes	__No	_____

Family History

Eye Diseases			Relationship to Patient
Amblyopia (lazy eye)	__Yes	__No	_____
Blindness	__Yes	__No	_____
Cataract(s)	__Yes	__No	_____
Color Blindness	__Yes	__No	_____
Eye Tumors	__Yes	__No	_____
Glaucoma	__Yes	__No	_____
Glaucoma Suspect	__Yes	__No	_____
Macular Degeneration	__Yes	__No	_____
Retinal Detachment	__Yes	__No	_____
Strabismus (eye turn)	__Yes	__No	_____
Other Eye Conditions			

Systemic Diseases			Relationship to Patient
Arthritis	__Yes	__No	_____
Cancer	__Yes	__No	_____
Diabetes	__Yes	__No	_____
Heart Disease	__Yes	__No	_____
High Blood Pressure	__Yes	__No	_____
Kidney Disease	__Yes	__No	_____
Lupus	__Yes	__No	_____
Stroke	__Yes	__No	_____
Thyroid Disease	__Yes	__No	_____

Other Disease _____

Social History – General

Current Occupation _____ ___ Years Employer_____
Employer Address _____ Phone _____
Do you drink alcohol? __No __Occasionally __1 per day __2-3 per day __4+ per day
Do you smoke? __No Occasionally __1/2 pack per day __1 pack per day __ 1+ pack per day
Past smoker: __Yes __No When did you quit smoking? _____
Smoking Status: __Never Smoked __ Former Smoker __ Current part-time __ Every day
Tobacco use cessation intervention: Counseling or pharmacologic therapy? __Yes __No
Do you chew tobacco? __Yes __No Do you use nutritional supplements? __ Yes __No
Do you use illegal drugs? __Yes __No Do you engage in regular exercise? __ Yes __No
Ethnicity: _____ Marital Status: S__ M__ D__ W__
When was your last health exam? _____
Any general surgeries? _____

Social History-Vision

Do you use a computer? __Yes __No Hours per day ___ Distance from computer _____
Do you drive? __Yes __No Daily Mileage ___ Visual difficulty while driving? __Yes __No
Do you have problem with glare?__Yes __No Any problems with night vision? __Yes __No
Have you had any eye surgeries or injuries? ___Yes ___No
What type and when?_____

Social History – Spectacles/Contact Lenses

Currently wear glasses? __Yes __No Since _____ Full-Time__Part-Time__ Dist.__ Near __
Glass currently worn __Single Vision __Safety __Bifocals __ Sport Glasses
__Trifocals __Progressive __Back-up glasses __ Other
When was your last eye exam?_____ Location _____
Have you had problems with glasses in the past? __Yes __No
Explain:_____
Do you wear sunglasses? __Yes __No Are they prescription lenses? __Yes __No
Special eyewear needs: __ Computer __Safety __Occupational __Sports/Hobbies

Do you currently wear contact lenses? __Yes __No Type and brand _____
Are you interested in a contact lens evaluation and new lenses? __Yes __No
When did you start wearing contacts? _____ Hours per day ____ Days per week __
Rate the comfort level of your contacts from 1-10 with 10 being the very comfortable.
Right _____ Left _____

In order to control the cost of billing, the patient's portion is paid at the time services are rendered unless other arrangements are made in advance. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Payments from my insurance company are to be paid directly to Janani K. Lannin, O.D. I understand that all benefits quoted to me are not a guarantee of payment by my insurance company and that final determination can only be made when the claim is processed by my insurance company.

Signature _____ Date: _____