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)

[ ] 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	[ ] Migraine Headaches	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 Infections	R L B	[ ] Mucus Discharge	R L B	[ ] Light Sensitive	R L B
[ ] Eye Pain/Soreness	R L B	[ ] Floaters or Spots	R L B	[ ] Sandy/Gritty Feeling	R L B
[ ] Tired eyes	R L B	[ ] See Flashes	R L B	[ ] Poor Color Vision	R L B
[ ] Burning Eyes	R L B	[ ] See Halos	R L B	[ ] Droopy Lid	R L B
[ ] Itchy Eyes	R L B	[ ] 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.**

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
___ Other:	___ 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 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 Degeneratior	Yes/No	
Thyroid Disease:	Yes/No		Retinal Detachment1:	Yes/No	

Reviewed by:

Dr _____ Date _____

Revised 01/08