

# Blue Earth Valley Eye Clinic Ltd.

## General Information

Date: \_\_\_/\_\_\_/\_\_\_

Last Name _____	First Name: _____	M _____	DOB: ___/___/___
M or F _____	SSN: _____/_____/_____	Marital Status: S / D / W / M : _____	Spouse Name: _____
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

Do you wear contacts? Yes No Type: \_\_\_\_\_

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

Glaucoma: Yes / No

Macular Degeneration: Yes / No

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

Blurred Vision/Distance	Burning Eyes	Floaters or Spots	Headaches *
Blurred Vision/Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive
Eye Pain/Soreness	Wandering eye	Droopy Lid	Sandy/Gritty Feeling
Tired eyes	Mucus Discharge		

Notes:

Confidential

**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.**

<b>Cardiovascular:</b> __ None <input type="checkbox"/> Hypertension <input type="checkbox"/> Stroke <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Cholesterol <input type="checkbox"/> Other:	<b>Endocrine:</b> __ None <input type="checkbox"/> Non-Insulin Dependent Diabetes <input type="checkbox"/> Insulin Dependent Diabetes <input type="checkbox"/> Thyroid Problem <input type="checkbox"/> Hormonal Dysfunction <input type="checkbox"/> Other:	<b>Respiratory:</b> __ None <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Other:
<b>Constitutional:</b> __ None <input type="checkbox"/> Cancer <input type="checkbox"/> Trauma/Large Volume Blood Loss <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other:	<b>Ocular</b> __ None <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Detached Retina <input type="checkbox"/> Other:	<b>Psychiatric:</b> __ None <input type="checkbox"/> ADHD <input type="checkbox"/> Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Other:
<b>Neurological:</b> __ None <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Parkinson's <input type="checkbox"/> Other:	<b>Musculoskeletal:</b> __ None <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Other:	<b>Immunologic:</b> __ None <input type="checkbox"/> AIDS or HIV <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Neurofibromatosis <input type="checkbox"/> Other:
<b>Hematological:</b> __ None <input type="checkbox"/> Anemia <input type="checkbox"/> Leukemia <input type="checkbox"/> Other:	<b>Gastrointestinal</b> __ None <input type="checkbox"/> Crohn's <input type="checkbox"/> Colitis <input type="checkbox"/> Other:	<b>Ear/Nose/Throat:</b> __ None <input type="checkbox"/> Hearing Loss <input type="checkbox"/> Upper Respiratory Infection <input type="checkbox"/> Other:
<b>Dermatologic:</b> __ None <input type="checkbox"/> Eczema <input type="checkbox"/> Rosacea <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other:	<b>Allergies (please list)</b> __ None Drug:  Environmental:	<b>Alcohol Use:</b> Y    N Amount:  <b>Tobacco Use:</b> Y    N Amount:

Please list physical reaction's) to above allergies: \_\_\_\_\_

Any major surgeries: \_\_\_\_\_

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 Detachmen	Yes/No	_____	Blindness:	Yes/No	_____
High Blood Pressur	Yes/No	_____	Cataracts:	Yes/No	_____
Diabetes:	Yes/No	_____	Glaucoma:	Yes/No	_____
Cancer:	Yes/No	_____	Crossed Eyes:	Yes/No	_____
Heart Disease:	Yes/No	_____	Macular Degenerat	Yes/No	_____
Thyroid Disease:	Yes/No	_____	Lupus	Yes/No	_____