Norcross Eye Center

Any prior injury or surgery? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you worn contacts or interested in them? Yes No

If worn, what kind/brand of lenses? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interested in Color Contacts? Yes No

If over the age 40; are you interested in multifocal contact lenses?

YES NO

Are you taking any eye medication/drops? Yes No

If yes, what is the name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check any that apply i.e. family member or self

Yes / No / Relationship

Dry Eyes Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Blindness Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cataracts Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Glaucoma Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heart disease Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Macular Degen. Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Disease Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

“Lazy” eye Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Retinal Detach. Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diabetes\* Y N \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Check any Symptoms that apply:**

Dry eyes \_\_\_ Excess Tearing \_\_\_ Double Vision \_\_\_

Red Eye \_\_\_ Flashing Lights\_\_\_ Light Sensitivity \_\_\_

Eye burn \_\_\_ Floaters in vision \_\_\_ loss of Vision \_\_\_

What is the reason for your visit today?

Annual Exam \_\_\_\_\_\_

Contact lens Exam \_\_\_\_\_\_

Medical Issue \_\_\_\_\_\_

Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medication:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies to Medication? YES NO

If yes, to what medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you been diagnosed/treated for conditions relating to?

Allergies Y N Cancer Y N

Arthritis Y N Cholesterol Y N

Blood/Anemia Y N Diabetes/Thyroid Y N

Respiratory problems Y N Digestive Y N

Skin/ rashes Y N Ear/nose/throat Y N

Urinary problems Y N Cardiovascular Y N

Bone/muscle Y N Psychological Y N

Neurological Y N Currently Pregnant Y N

**Patient Medical History**

**Family Medical/Eye History**

**Patient Eye History**

First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_-\_\_\_\_-\_\_\_\_\_ Sex: M F Date:\_\_\_\_/\_\_\_\_/\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_ ZIP\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_ Home/Cell (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_Work/Cell (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Whom can we thank for referring you?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_