Dr Tufte's Eyes On 45th

Date ____/____/____

Patient History Information

Last Name:_____ **First Name:**_____ **MI:**_____ **DOB:**___/___/___

M or F SSN:___-___-___ Marital Status: Married - Single - Divorced - Widowed

Address:_____ City:_____ State:_____ Zip:_____

Phone Home:_____ Work:_____ **Cell:**_____

Employer:_____ Occupation/School:_____

Email:_____ Sports/Hobbies:_____

Emergency Contact:_____ Relation:_____ Phone:_____

How did you hear about our clinic? _____

Whom may we thank for your referral?_____

Sign me up for: **Smile Reminder Text - Yes / No** **Smile Reminder Email - Yes / No**

Do you wear glasses? Yes / No / All the Time / Sometimes / Work Only / Reading Only / Driving Only

Are you interested in looking at new glasses? _____

How old are your present glasses? _____ Do you wear prescription sunwear?_____

Do you wear contacts? _____ Brand: _____ Solution Used: _____

Wearing Schedule: **Daily** **Overnight** Replacement Schedule: **Daily** **2 week** **Monthly** **Other**_____

Date of last Medical Exam: ____/____/____ Primary Care Physician/Clinic: _____

Date of last Eye Exam: ____/____/____ Eye Doctor /Clinic: _____

Case History / Reason for Visit

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?_____
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

What are your visual symptoms? (Check all that apply):

- □ 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 Eyes
- □ Wandering Eyes
- □ Mucus Discharge
- □ Floaters/Spots
- □ See Flashes
- □ See Halos
- □ Poor Night Vision
- □ Headaches
- □ Migraine Headaches
- □ Loss of Vision
- □ Crossed Eyes
- □ Light Sensitive
- □ Sandy/Gritty Feeling
- □ Poor Color Vision
- □ Droopy Lids

Reviewed By

Dr. _____ **Date** _____

Please turn over and complete other side

Personal Medical History (Review of Systems): Please check if any of the following conditions applies to you and list any medications for each condition. If you have none of these conditions, please check none.

Cardiovascular: □None □ Heart Disease □ Hypertension □ Stroke □ Vascular Disease □ Other:	**Constitutional:** □None □ Cancer □ Trauma/Large Blood Loss □ Developmental Disability □ Other:	**Dermatologic:** □None □ Eczema □ Rosacea □ Psoriasis □ Other:
Ear/Nose/Throat: □None □ Hearing Loss □ Upper Respiratory Infection □ Other:	**Endocrine:** □None □ Non-Insulin Dependent Diabetes □ Insulin Dependent Diabetes □ Thyroid Problem □ Hormonal Dysfunction □ Other:	**Gastrointestinal:** □None □ Crohn's □ Colitis □ Other:
Hematological: □None □ Anemia □ Leukemia □ Hemophiliac □ Other:	**Immunologic:** □None □ AIDS or HIV □ Rheumatoid Arthritis □ Lupus □ Neurofibromatosis □ Other:	**Musculoskeletal:** □None □ Osteoarthritis □ Fibromyalgia □ Muscular Dystrophy □ Ankylosing Spondylitis □ Other:
Neurological: □None □ Multiple Sclerosis □ Epilepsy □ Cerebral Palsy □ Tumor □ Other:	**Ocular:** □None □ Glaucoma □ Cataract □ Macular Degeneration □ Detached Retina □ Other:	**Psychiatric:** □None □ ADHD □ Depression □ Schizophrenia □ Other:
Respiratory: □None □ Asthma □ Bronchitis □ Emphysema □ COPD □ Other:	**Allergy:** (Please List) Drug: Environmental:	□None **Social:** Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list physical reactions to above allergies: _____

_____

Please list all medications you are taking (including herbal): See attached list ____

1 _____ For _____
2 _____ For _____
3 _____ For _____
4 _____ For _____
5 _____ For _____
6 _____ For _____
7 _____ For _____
8 _____ For _____
9 _____ For _____
10 _____ For _____

Family History: Please list all family members (grandparents, parents, siblings, children) diagnosed with the following:

Disease/Condition

Retinal Detachment Yes/No _____
High Blood Pressure Yes/No _____
Diabetes Yes/No _____
Cancer Yes/No _____
Heart Disease Yes/No _____
Thyroid Disease Yes/No _____
Blindness Yes/No _____
Cataracts Yes/No _____
Glaucoma Yes/No _____
Crossed Eyes Yes/No _____
Macular Degeneration Yes/No _____
Lupus Yes/No _____