

## Low Country Vision Center

Name: \_\_\_\_\_ MI: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_ Apt#: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Business Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ X \_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Occupation: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_ @ \_\_\_\_\_

Last Medical Exam: \_\_\_\_\_ Name of Medical Doctor: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_ Doctor's Phone: \_\_\_\_\_

Insurance: \_\_\_\_\_

Member Name/SSN/DOB \_\_\_\_\_

Email Address \_\_\_\_\_

### Medical History

Do you have any allergies to foods/ medications?  no  yes, if yes please explain \_\_\_\_\_

List any medications you take (include oral contraceptives, aspirin or other over the counter medications)

\_\_\_\_\_

\_\_\_\_\_

List all major injuries, surgeries and/or hospitalizations you have had: \_\_\_\_\_

\_\_\_\_\_

Circle any of the following that you have had: Crossed eyes Lazy eye Drooping eyelid Prominent eyes  
 Glaucoma Retinal disease Cataracts Eye infection and/or injury \_\_\_\_\_

Are you pregnant and/or Nursing?  no  yes  
 Do you wear glasses?  no  yes If yes, how old are your present lenses? \_\_\_\_\_  
 Do you wear contact lenses?  no  yes If yes, how old are your present lenses? \_\_\_\_\_  
 Type of contact lenses:  rigid  soft  extended wear  other \_\_\_\_\_  
 Are they comfortable?  yes  no

### Family History

Please note any history (parents, grandparents, siblings and/or children; living or deceased) for the below:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### Social History

Do you play sports?  yes  no If yes, what sports? \_\_\_\_\_

Do you drive?  no  yes If yes, do you have visual difficulty when driving?  no  yes, describe \_\_\_\_\_

Do you use tobacco products?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you drink alcohol?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Do you use illegal drugs?  no  yes If yes, type/amount/how long: \_\_\_\_\_

Have you ever been exposed to or infected with:  Gonorrhea  syphilis  HIV  Hepatitis

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### Review Of Medical Systems

Do you currently, or have you ever had any problems in the following areas: (If YES, Please explain & list)

SYSTEM	NO	YES	?	EXPLAIN/MEDICATIONS
SKIN	[ ]	[ ]	[ ]	_____
NEURALGIC				_____
Headaches	[ ]	[ ]	[ ]	_____
Migraines	[ ]	[ ]	[ ]	_____
Seizures	[ ]	[ ]	[ ]	_____
EYES				_____
Loss of Vision	[ ]	[ ]	[ ]	_____
Blurred Vision	[ ]	[ ]	[ ]	_____
Distorted Vision/halos	[ ]	[ ]	[ ]	_____
Loss of Side Vision	[ ]	[ ]	[ ]	_____
Double Vision	[ ]	[ ]	[ ]	_____
Dryness / Burning	[ ]	[ ]	[ ]	_____
Mucous Discharge	[ ]	[ ]	[ ]	_____
Redness	[ ]	[ ]	[ ]	_____
Sandy or Gritty Feeling	[ ]	[ ]	[ ]	_____
Itching	[ ]	[ ]	[ ]	_____
Foreign Body Feeling	[ ]	[ ]	[ ]	_____
Excess Tearing/Watering	[ ]	[ ]	[ ]	_____
Glare/Light Sensitivity	[ ]	[ ]	[ ]	_____
Eye Pain/Soreness	[ ]	[ ]	[ ]	_____
Chronic Infections	[ ]	[ ]	[ ]	_____
Sties or Chalazion	[ ]	[ ]	[ ]	_____
Flashes/Floater	[ ]	[ ]	[ ]	_____
Tired Eyes	[ ]	[ ]	[ ]	_____
EARS, NOSE, MOUTH, THROAT				_____
Allergies/Hay Fever	[ ]	[ ]	[ ]	_____
Sinus Congestion	[ ]	[ ]	[ ]	_____
Runny Nose	[ ]	[ ]	[ ]	_____
Postnasal Drip	[ ]	[ ]	[ ]	_____
Chronic Cough	[ ]	[ ]	[ ]	_____
Dry Throat/Mouth	[ ]	[ ]	[ ]	_____
RESPIRATORY				_____
Asthma	[ ]	[ ]	[ ]	_____
Chronic Bronchitis	[ ]	[ ]	[ ]	_____
Emphysema	[ ]	[ ]	[ ]	_____
VASCULAR				_____
Diabetes	[ ]	[ ]	[ ]	_____
Heart Pain	[ ]	[ ]	[ ]	_____
High Blood Pressure	[ ]	[ ]	[ ]	_____
Vascular Disease	[ ]	[ ]	[ ]	_____
GASTROINTESTINAL				_____
Diarrhea [ ]	[ ]	[ ]	[ ]	_____
Constipation	[ ]	[ ]	[ ]	_____
GENITOURINARY				_____
Kidneys/Bladder/Genitals	[ ]	[ ]	[ ]	_____
BONES/JOINTS/MUSCLES				_____
Rheumatoid Arthritis	[ ]	[ ]	[ ]	_____
Muscle/Join Pain	[ ]	[ ]	[ ]	_____
LYMPHATIC/HEMATOLOGIC				_____
Anemia	[ ]	[ ]	[ ]	_____
Bleeding Problems	[ ]	[ ]	[ ]	_____
ENDOCRINE(Thyroid/oth. gland)	[ ]	[ ]	[ ]	_____
PSYCHIATRIC	[ ]	[ ]	[ ]	_____