## 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 your 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 | [ ] | [ ] | [ ] | _____ |
| Cataract | [ ] | [ ] | [ ] | _____ |
| Crossed Eyes | [ ] | [ ] | [ ] | _____ |
| Glaucoma | [ ] | [ ] | [ ] | _____ |
| Macular Degeneration | [ ] | [ ] | [ ] | _____ |
| Retinal Detachment/Disease | [ ] | [ ] | [ ] | _____ |
| Arthritis | [ ] | [ ] | [ ] | _____ |
| Cancer | [ ] | [ ] | [ ] | _____ |
| Diabetes | [ ] | [ ] | [ ] | _____ |
| Heart Disease | [ ] | [ ] | [ ] | _____ |
| High Blood Pressure | [ ] | [ ] | [ ] | _____ |
| Other_____ | [ ] | [ ] | [ ] | _____ |

### 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

## Low Country Vision Center

### 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/Floatera | [ ] | [ ] | [ ] | |
| 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 | [ ] | [ ] | [ ] | |