Anna Eyecare, PA
OCULAR / MEDICAL HISTORY

(Please Print)

Today's Date:	Patient's Name:

REASON FOR VISIT

Name of Previous Eye Doctor:	Date of Last Eye Exam:

What is Your Chief Complaint? (*Reason for visit*):

Today's Examination is Especially For (*check all that apply*):

☐ Glasses ☐ Contact Lenses ☐ Lasik ☐ Routine Yearly Exam

☐ Eye Infection or Injury (*please explain*)_____

☐ Other_____

Do you currently wear contact lenses? ☐ Yes ☐ No If yes, what type/brand?_____

Are you happy with your contact lenses? ☐ Yes ☐ No If no, why not?_____

Do you want to wear contacts? ☐ Yes ☐ No ☐ Clear ☐ Color ☐ Both

Do you wish you could sleep in your lenses? ☐ Yes ☐ No

Do you currently sleep in your lenses? ☐ Yes ☐ No

OCULAR HISTORY

Please check yes or no if the patient has any of the following ocular conditions. If an immediate family member has any of these ocular conditions check the box and please indicate who.

	Yes	No	In Family		Yes	No	In Family
Glaucoma	☐	☐	☐_____	Other Eye Diseases	☐	☐	☐_____
Cataract	☐	☐	☐_____	*If yes, please explain*			_____
"Lazy Eye"	☐	☐	☐_____	Eye Surgery	☐	☐	☐_____
Macular Degeneration	☐	☐	☐_____	*If yes, please explain*			_____
Retinal Detachment	☐	☐	☐_____	Eye Injury (*explain*)	☐	☐	☐_____

Please check the Eye/Vision symptoms the patient is experiencing:

☐ Headaches / Blank Spots in Vision	☐ Distance Vision Blurry	☐ Drooping Eyelid
☐ Difficulty When Driving at Night	☐ Eyes Feel Tired with Near Tasks	☐ Eyes Burn with Computer Use
☐ Eyes Feel Scratchy, Gritty, or Sandy	☐ Eyes Water Excessively	☐ Crossed Eye "Lazy Eye"
☐ Double Vision	☐ Glare or Light Sensitivity	☐ Sudden or Slow Loss, Blurred, Fluctuating
☐ Frequent Styes	☐ Red – Dry – Itching – Burning	☐ Light Flashes / Spots or "Floaters"
☐ Holds Reading too Close	☐ Must Hold Reading Farther Away	☐ Other _____
☐ Mucous Discharge-Infection of Eye or Lid	☐ Foreign Body Sensation	
☐ Loss of Peripheral (side) Vision	☐ Squinting	
☐ Curtain or Veil in Vision	☐ Near Vision Blurry	

Please check your job or hobby activities:

☐ Reading	☐ Studying	☐ Computer Use	☐ Desk Work	☐ Drafting
☐ Sewing	☐ Crafts	☐ Reading in Bed	☐ Machine Operation	☐ Home Workshop
☐ Musical Instrument	☐ Piano	☐ Card Playing	☐ TV	☐ Fishing
☐ Golf	☐ Tennis	☐ Biking	☐ Swimming	☐ Flying
☐ Racquetball	☐ Scuba Diving	☐ Sky Diving	☐ Mountain Climbing	☐ Baseball/Softball
☐ Team Sport	☐ Other _____			

MEDICAL HISTORY

Last Medical Exam:	Results:	Primary Care Physician:

Please check yes or no if the patient has any of the following medical conditions. If an immediate family member has any of these medical conditions check the box and please indicate who.

	Yes	No	Family		Yes	No	Family
Allergies	☐	☐	☐_____	Heart Disease	☐	☐	☐_____
Arthritis	☐	☐	☐_____	High Blood Pressure	☐	☐	☐_____
Asthma	☐	☐	☐_____	Kidney Problems	☐	☐	☐_____
Diabetes	☐	☐	☐_____	Nervous System	☐	☐	☐_____
Cancer	☐	☐	☐_____	Skin Disorder	☐	☐	☐_____
Cholesterol	☐	☐	☐_____	Thyroid Disorder	☐	☐	☐_____

Other _____

List all medications, prescriptions or over the counter, that you're currently taking and the purpose for each:

List any allergies to medications:

Check yes or no if you use any of the following:

	Yes	No	
Tobacco	☐	☐	If yes, how often?_____
Alcohol	☐	☐	If yes, how often?_____
Illicit Drug Use	☐	☐	If yes, how often?_____

DILATION PROTOCOL

HERE AT ANNA EYECARE WE STRIVE TO GIVE YOU THE BEST QUALITY CARE POSSIBLE. THE STANDARD OF CARE FOR OCCULAR HEALTH IS A DILATED EXAM. A DILATED EXAM IS IMPORTANT BECAUSE IT ALLOWS MORE OF THE INTERNAL STRUCTURES OF THE EYE TO BE VIEWED IN ORDER TO RULE OUT RETINAL PATHOLOGIES INCLUDING DETACHMENTS, TEARS, TUMORS, ETC. COMMON SIDE EFFECTS INCLUDE SENSITIVITY TO LIGHT AND REDUCED NEAR VISION. THESE SIDE EFFECTS USUALLY LAST 2-4 HOURS. PLEASE CHECK ONE OF THE FOLLOWING BOXES BELOW.

( ) I WOULD LIKE TO HAVE A DILATED FUNDUS EXAM PERFORMED TODAY

( ) I UNDERSTAND THE IMPORTANCE OF THE DILATED FUNDUS EXAM, BUT I DO NOT WITH TO BE DILATED TODAY

( ) I WOULD LIKE TO DISCUSS IT WITH THE DOCTOR

Patient/Guardian Signature_____Date_____