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Questions outlined in red will save only to the PDF file, available in Interview History

Date: ________________

DEMOGRAPHICS

First Name ________________ Middle name ________________ Last name ________________

Address ________________________________ Suffix ________________

City ________________ State ________________ Zip Code ________________

Date of Birth ________________ SSN ________________ Sex ○ Male ○ Female

Cell phone ________________ Home phone ________________ Work phone ________________

Preferred contact method ☐ Cell ☐ Home ☐ Work

Email ________________________ Language ________________________

Race ________________________ Ethnicity ________________________

Marital status ○ Single ○ Married ○ Other

Employment status

○ Employed Full Time ○ Employed Part Time ○ Student Full Time

○ Student Part Time ○ Not Employed ○ Retired

○ Homemaker ○ Active Military ○ Disabled

What is your driver's license number? ________________________

Who is your employer? ________________________

What is your position/occupation? ________________________

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INSURANCE INFORMATION

PRIMARY INSURANCE

Insurance Company Name ______________________________

Policy Holder ______________________ Policy Holder Date of Birth ______________

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number ______________________________

SECONDARY INSURANCE:

Insurance Company Name ______________________________

Policy Holder ______________________ Policy Holder Date of Birth ______________

Relationship of Policy Holder ○ Spouse ○ Child ○ Other

Policy Number ______________________________

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REASON FOR VISIT

Please tell us why you're coming to see us ______________________________

If another provider sent you to us, who? ______________________________

EYE HISTORY

When was your last eye exam? ______________________________

Who was your previous eye doctor?

Have you ever had any eye injuries, surgeries for your eyes, or been diagnosed with an eye disease?

- ☐ No conditions
- ☐ Glaucoma suspect
- ☐ Glaucoma
- ☐ Cataract
- ☐ Age related macular degeneration
- ☐ Surgery
- ☐ Patching
- ☐ Inflammatory disorders
- ☐ Strabismus
- ☐ Amblyopia
- ☐ Retinal degeneration
- ☐ Retinal hole
- ☐ Retinal detachment
- ☐ Keratoconus

Do you wear glasses? ○ Yes ○ No

How old are your glasses? ______________________________

What don't you like about your current glasses? ______________________________

Do you wear contact lenses? ○ Yes ○ No

What brand of contact lenses do you wear? ______________________________

What is your contact lens prescription for the right eye? ______________________________

What is your contact lens prescription for the left eye? ______________________________

What solution(s) do you use to clean your contact lenses? ______________________________

Do you sleep in your contact lenses? ○ Yes ○ No

How often do you start a new pair of lenses? ○ Daily ○ Monthly ○ Quarterly ○ Other

What don't you like about your contact lenses? ______________________________

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HISTORY OF PRESENT ILLNESS

Are you having any problems with your eyes? ○ Yes ○ No

What problem are you having? ______________________________

Which eye is affected? ______________________________

How would you describe the quality of the problem?

☐ Awareness ☐ Bothersome ☐ Painful

How would you describe the severity of the problem?

○ Mild ○ Moderate ○ Severe

When did the problem begin? ______________________________

Have you ever had this problem before?

○ New Condition ○ Return of Previous Condition ○ Ongoing Condition

Is the problem associated with any of the following conditions?

○ Associated with injury ○ Associated with infection
○ Associated with medical condition ○ Associated with surgery

What have you done to try to make the problem better?

☐ Taking medication ☐ Taking drops ☐ Treated by another provider

Are any symptoms associated with the problem?

☐ Burning ☐ Loss of vision
☐ Tearing ☐ Headache
☐ Mattering ☐ Photophobia
☐ Flashes ☐ Diplopia
☐ Floaters ☐ Red
☐ Loss of sharpness ☐ Itching

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REVIEW OF SYSTEMS

Allergy/Immunology
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Allergies
- ☐ Lupus
- ☐ Sjogren's Syndrome
- ☐ Other

Hematology/Lymphatic
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other

Cardiovascular
- ☐ Hypertension
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/CVA
- ☐ Other

Psychological
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder

Gastrointestinal
- ☐ Crohns
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflux
- ☐ Celiac Disease
- ☐ Other

Neurological
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Tumors
- ☐ Stroke/CVA
- ☐ Migraines
- ☐ Autism Spectrum Disorder
- ☐ Epilepsy
- ☐ Other

Ear, Nose & Throat
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other

Integumentary
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Herpest Simplex/ Cold Sores
- ☐ Herpes Zoster/ Shingles
- ☐ Other

Genitourinary
- ☐ Kidney Disease
- ☐ Prostate Disease
- ☐ STD-herpetic/chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant
- ☐ Nursing
- ☐ Herpes
- ☐ Chlamydia
- ☐ Other

Musculoskeletal
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Osteoarthritis
- ☐ Other

Constitution
- ☐ Developmental Disabilities
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other

Respiratory
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other

Endocrine
- ☐ Type 2 Diabetes Mellitus
- ☐ Type 1 Diabetes Mellitus
- ☐ Thyroid dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other

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MEDICATIONS

Do you take any prescription or non-prescription medications? ○ Yes ○ No

What is the name of the medication?	How often do you take this medication?

Please feel free to share any information about your medications here

____

What pharmacy do you use? ______________________________

ALLERGIES

Are you allergic to any medications? ○ Yes ○ No

What medication(s) are you allergic to?	How severe is your allergy?	

Do you have any other allergies? ○ Yes ○ No

What other allergies do you have? ______________________________

Are you allergic to latex? ○ Yes ○ No

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PAST, FAMILY AND SOCIAL HISTORY

Who is your primary care physician? ____________________

DIABETES HISTORY

Do you have diabetes? ○ Yes ○ No

How long have you had diabetes? ____________________

What physician is treating your diabetes? ____________________

How frequently do you see your physician for diabetes care? ____________________

What was your last hemoglobin A1c reading? ____________________

FAMILY MEDICAL HISTORY

Does anyone in your family have any of the following medical conditions?

☐ None ☐ Hypertension ☐ Diabetes ☐ Cancer ☐ Thyroid ☐ Other

Does anyone in your family have any of the following eye conditions?

☐ No conditions ☐ Severe Myopia ☐ Macular Degeneration ☐ Cataract
☐ Glaucoma suspect ☐ Severe Hyperopia ☐ Amblyopia ☐ Patching
☐ Glaucoma ☐ Strabismus ☐ Retinal Detachment ☐ Other

SOCIAL HISTORY

Do you drink alcohol? ○ Yes ○ No

How often do you drink alcohol? ____________________

Do you use tobacco products? ○ Yes ○ No

Do you use tobacco products?

☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Smokeless tobacco ☐ Other

How often do you use tobacco products? ____________________

Do you currently or have you ever smoked tobacco products?

☐ Smoker ☐ Never smoker ☐ Former smoker ☐ Current some day smoker
☐ Current every day smoker ☐ Heavy toboacco smoker ☐ Light tobacco smoker

Do you have any hobbies? ____________________