

# TOTAL EYECARE

Robert A. Colon, OD Kurt G. Alleman, OD Colby B. Curtis, OD

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Optos Retinal Scan: Yes / No

Main Reason for Today's Visit: \_\_\_\_\_

Name of Current Medical Physician: \_\_\_\_\_

What hobbies do you enjoy: \_\_\_\_\_

- Do you wear contact lenses: *Yes / No* If yes: what solutions do you use: \_\_\_\_\_
- Are you interested in Contact lenses: *Yes / No*
- Do you wear glasses? *Yes / No*
- Do you have a second pair/ back up pair of glasses? *Yes / No*
- Do you do a lot of close-up work? *Yes / No*
- Do you work at the computer for extended periods of time? *Yes / No*
- Do you have a pair of sunglasses? *Yes / No* Prescription / Non- prescription
- Are you having any problems with your current eyewear? (please explain)

## Please explain any vision troubles you are having:

Difficulty reading? Yes / No  
Blurry distance vision? Yes / No  
Trouble seeing at night? Yes / No  
Trouble seeing computer? Yes / No  
Double vision? Yes / No  
Floaters or spots in vision? Yes / No  
Flashes of light in vision? Yes / No  
Other? \_\_\_\_\_

## Please explain any eye symptoms you are having:

Glare or reflections? Yes / No  
Eye strain or fatigue? Yes / No  
Red eyes? Yes / No  
Dry, gritty, or sandy feeling? Yes / No  
Burning sensation? Yes / No  
Itchy eyes? Yes / No  
Watery or teary eyes? Yes / No  
Sore eyes? Yes / No  
Sensitive to light? Yes / No  
Other? \_\_\_\_\_

## Are you currently experiencing:

Headaches? Yes / No  
Dizziness? Yes / No  
Fainting? Yes / No  
Nausea? Yes / No

## For our female patients:

Are you currently pregnant? Yes / No

Breastfeeding? Yes / No

## Please explain any FAMILY medical history:

Diabetes *Yes / No* Relationship: \_\_\_\_\_ Heart Disease *Yes / No* Relationship: \_\_\_\_\_

Blindness *Yes / No* Relationship: \_\_\_\_\_ Cataracts *Yes / No* Relationship: \_\_\_\_\_

Glaucoma *Yes / No* Relationship: \_\_\_\_\_ Macular Degeneration *Yes / No* Relationship: \_\_\_\_\_

## Please list any allergies you have, including allergies to any medications:

## Please list any medications you are currently taking.

## Please list any eye medications including over-the-counter eye drops:

## Please explain any PERSONAL medical history:

Diabetes? Yes / No  
High blood pressure? Yes / No  
High cholesterol? Yes / No  
Asthma? Yes / No  
Heart disease? Yes / No  
Cancer? Yes / No  
Arthritis? Yes / No  
Thyroid disease? Yes / No  
Surgeries? Yes / No  
If yes, what kind? \_\_\_\_\_  
Other? \_\_\_\_\_

## Please explain any PERSONAL eye history:

Cataracts? Yes / No  
Glaucoma? Yes / No  
Macular degeneration? Yes / No  
Lazy eye? Yes / No  
Other? \_\_\_\_\_

## Previous eye surgeries:

Cataract? Yes / No  
LASIK? Yes / No  
Eye muscle? Yes / No  
Retinal detachment? Yes / No  
Injections? Yes / No  
Other? \_\_\_\_\_

Do you use any Tobacco products? Yes / No