Name _____ **Birthdate** _____ **Preferred Language**_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Race: ☐ American Indian/Alaskan ☐ Asian ☐ Black/African American ☐ Hawaiian or Pacific Islander ☐ White

Review of Systems *Please mark any known conditions and explain below.*

□ **No known problems**	□ General/Constitutional	□Ears/Nose/Throat/Mouth	□Cardiovascular
□ Respiratory	□ Gastrointestinal	□ Neurological	□ Musculoskeletal
□ Integumentary/ Skin	□ Psychiatric	□ Endocrine	□ Lymphatic
□ Allergic/ Immunologic			

Please explain _____

_____

Family History

□ **No known problems**	□ High blood pressure	□ Cancer	□ Stroke
□ Heart Disease	□ Diabetes	□ Thyroid Disease	□ Lazy Eye
□ Crossed Eyes	□ Glaucoma	□ Macular Degeneration	□ Other_____

Current Symptoms

□ **No current symptoms**	□ Blurred Vision	□ Headaches	□ Double Vision
□ Eye Pain	□ Dry Eyes	□ Watery Eyes	□ Flashing Lights
□ Eye Fatigue	□ Floating Objects	□ Loss of Vision (black out)	□ Itchy Eyes
□ Other _____			

Personal Eye History

□ **None of the below**	□ Eyeglasses	□ Contact Lenses	□ Eye Injury
□ Lazy Eye	□ Crossed Eyes	□ Vision Therapy	□ Glaucoma
□ Cataracts	□ Keratoconus	□ Retinal Detachment	□ Diabetic Retinopathy
□ Macular Degeneration	□ Eye Surgery (explain)_____		

Medications □ **I take NO medication**

Prescription Meds:_____

Over-the-counter Meds:_____

Allergies □ **I have NO known allergies**

Allergy to medications_____Other Allergies_____

Social History

Occupation:_____ Use a computer? □ No □ Yes (Hrs/Day_____)

Do you smoke? □ No □ Yes Do you drink alcohol? □ No □ Yes Do you use illegal drugs? □ No □ Yes

Hobbies/Activities_____

Contact Lens History □ **Not Applicable**

Type of contacts you currently wear:_____ How often do you replace your lenses? _____

Do you sleep in your contacts? □ No □ Yes If yes, how often?_____

Any problems with your current lenses?_____

Dilated Eye Exam: I understand that my eyes may be dilated in the course of my exam, and as a consequence, I may experience blurring of vision and sensitivity to light. This may make it difficult to read, drive or carry out normal visual activities until the effect of the dilation wears off. Allergic reactions to the medication may occur but are very rare. Dark glasses will be provided at the end of the visit to provide comfort from bright light. I also understand that a dilated eye exam helps to detect serious eye conditions, however, I may ask the doctor/staff of *Insight Eye Care* not to dilate my eyes.

_____ _____

Signature of Patient (or patients representative) Date

_____

Optometrist Signature