Welcome to North Lake Eyecare Optometry

Name:_____ Date:_____
Mailing Address:_____ City_____ St_____ Zip_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
E-mail Address_____
Birthdate:_____ Social Security#_____ Last Eye Exam_____
Primary reason for today's visit:_____

Whom may we thank for referring you to our office? ☐Goggle ☐ Internet ☐Friend/Family ☐ Other_____

MEDICATIONS Name of Medication Dosage Frequency-times per day?
List any medications you take 1)_____
2)_____
3)_____
4)_____
List any allergies to medications ☐ none ☐ penicillin ☐ sulfa ☐ other_____
Name of medical doctor:_____ Last medical exam:_____

Do you wear glasses? ☐No ☐Yes If yes, how old are your present glasses?_____
Do you wear contacts? ☐No ☐Yes If yes, what type and brand?_____
Have you had any eye surgeries/injuries & date?_____

Review of Systems
Do you currently, or have you ever had any problems in the following areas:

	Yes	No
CONSTITUTIONAL		
Developmental Disabilities	☐	☐
Cancer	☐	☐
Fatigue Syndrome	☐	☐
EAR, NOSE & THROAT		
Hearing Loss	☐	☐
Sinusitis	☐	☐
Dry Mouth	☐	☐
Laryngitis	☐	☐
NEUROLOGICAL		
Multiple Sclerosis	☐	☐
Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Tumor	☐	☐
Stroke	☐	☐
Migraine	☐	☐
PSYCHIATRIC		
Depression	☐	☐
Attention Deficit	☐	☐
Anxiety Disorder	☐	☐
Bipolar Disorder	☐	☐
CARDIOVASCULAR		
High Blood Pressure	☐	☐
Heart Disease	☐	☐
Vascular Disease	☐	☐
Congestive Heart Failure	☐	☐

	Yes	No
RESPIRATORY		
Asthma	☐	☐
Chronic Bronchitis	☐	☐
Emphysema	☐	☐
Chronic Obstructive	☐	☐
Sleep Apnea	☐	☐
GASTROINTESTINAL		
Crohn's Disease	☐	☐
Colitis	☐	☐
Ulcer	☐	☐
Acid Reflux	☐	☐
Celiac Disease	☐	☐
GENITOURINARY	☐	☐
Kidney Disease	☐	☐
Prostate Disease/Cancer	☐	☐
STD-Herpes or Chlamydia	☐	☐
MUSCULOSKELETAL	☐	☐
Arthritis	☐	☐
Fibromyalgia	☐	☐
Muscular Dystrophy	☐	☐
Osteoporosis	☐	☐
Gout	☐	☐
INTEGUMENTARY		
Eczema	☐	☐
Rosacea	☐	☐
Psoriasis	☐	☐
Herpes Simplex/Cold Sore	☐	☐
Herpes Zoster/Shingles	☐	☐

PLEASE COMPLETE NEXT PAGE

Name_____

	Yes	No
ENDOCRINE		
Diabetes Type I	☐	☐
Diabetes Type II (typically adult)	☐	☐
Thyroid Dysfunction	☐	☐
Hormonal Dysfunction	☐	☐
HEMOTOLOGICAL/LYMPHATIC		
Anemia	☐	☐
Blood loss (large volume)	☐	☐
Ulcer	☐	☐
High Cholesterol	☐	☐
ALLERGY/IMMUNE		
Lupus	☐	☐
Sjogren's Syndrome	☐	☐

	Yes	No
EYE HEALTH CONDITIONS		
Glaucoma	☐	☐
Cataract	☐	☐
Macular Degeneration	☐	☐
Dry eyes	☐	☐
Strabismus (eye turn)	☐	☐
Amblyopia (poor vision in one eye)	☐	☐
Retinal Detachment	☐	☐
Keratoconus	☐	☐
Other_____	☐	☐
FEMALES ONLY		
Are you pregnant?	☐	☐
Are you nursing?	☐	☐

FAMILY HISTORY *Please note any immediate family history for the following conditions*

DISEASE/CONDITIONS	Yes	No	RELATIONSHIP TO YOU *if yes circle one or more*					
Cancer	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type I or Type II(circle)	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Hyperthyroidism (high thyroid)	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Hypothyroidism (low thyroid)	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Cataract	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Macular Degeneration	☐	☐	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	☐	☐	Father	Mother	Brother	Sister	Son	Daughter

Social History

	Yes	No	
Do you use tobacco products?	☐	☐	If yes, type/amount/how long:_____
Do you drink alcohol?	☐	☐	If yes, type/amount/how long:_____

RETINAL IMAGING/PHOTO

Digital retinal photography is an advanced procedure that utilizes a **highly specialized retinal camera.** It is a photographic document of the inner lining of the eye. Since nothing touches the eye, it is painless and has no side effects. With retinal photography we are able to detect early signs of retinal problems, and manage them before your vision is ever damaged. With some cases, insurance may cover or reduce the cost

The fee is $47 for an image of both eyes. We recommend the procedure for all patients on their first visit and then every 1 to 2 years.

□ Yes, I consent to retinal imaging ($47).
□ I would like to discuss this procedure with the doctor.

RETINAL IMAGING RECOMMENDED DURING COVID PANDEMIC