Welcome to North Lake Eyecare Optometry

Name: _____

Mailing Address: _____ City:_____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

Birth date: _____ Social Security #: _____ Last Exam: _____

Preferred Language __English __Spanish Parent/Gaurdian Name: _____

Whom may we thank for referring you to our office? __Google __Internet __Friend/Family __Other

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 (ROS)

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

CONSTITUTIONAL	Yes	No
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 (Hypertension)		
Heart Disease		
Vascular Disease		
Congestive Heart Failure		
RESPIRATORY		
Asthma		
Chronic Bronchitis		
Emphysema		
Chronic Obstruction		
Sleep Apnea		

Other_____

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

MEDICATIONS: Name of Medication Dosage Frequency-times/day

List any medications you take:
1)_____
2)_____
3)_____
4)_____

ALLERGIES: List any allergies to medications __none __penicillin __sulfa __other_ _ _ _ _ _ _ _

Name of medical doctor: _____ Last medical exam: _____

EYE HEALTH CONDITIONS	Yes	No
Glaucoma		
Cataract		
Macular Degeneration		
Dry eyes		
Strabismus (eye turn)		
Amblyopia (poor vision in one eye)		
Retinal Detachment		
Keratoconus		
Other_____		

FEMALES ONLY	Yes	No
Are you pregnant?		
Are you nursing?		

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

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			Father Mother Brother Sister Son Daughter
Diabetes Type II			Father Mother Brother Sister Son Daughter
High Blood Pressure (Hypertension)			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

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 or 2 years.

	Yes, I consent to retinal imaging (**$47.00**)
	I would like to discuss this procedure with the doctor.