

WELCOME TO ALISO HILLS OPTOMETRIC GROUP
(PLEASE PRINT)

Last Name _____ First Name _____ Today's Date ____/____/____
 How would you like us to address you? First Name Formal Name Middle Mr Mrs Ms Dr
 Address _____ City _____ Nickname _____
 Home Phone (____) _____ Work Phone (____) _____ Zip _____
 Social Security # _____ Birth Date ____/____/____ Cell Phone (____) _____
 E-Mail _____ Last Eye Exam _____ Age _____ Gender: F M
 Medical Doctor _____ Referred By _____ Occupation _____

How did you hear about our office? Family Friend Doctor Insurance Internet Other _____

GLASSES AND CONTACT LENS HISTORY

What sports and hobbies do you enjoy? _____
 Are you interested in: Contact Lenses? No Yes
 Laser Vision Correction? No Yes
 Do you wear glasses? No Yes Used for: Distance Near Computer
 Do you wear contact lenses? No Yes If yes, please answer the following:
 Type of Contact Lenses: Soft Gas Permeable CRT
 Do you sleep in your lenses? No Yes Sometimes
 Do you replace your lenses every: Day Week 2 Weeks Month 3-4 Months Year Other
 Solutions: Optifree Renu Clear Care Complete Generic Boston Other _____
 Have you ever had an adverse reaction to any eye drops or contact lens solutions? No Yes _____

FAMILY HISTORY (parents, grandparents, brothers, sisters, children; living or deceased)

M=mother F=father MGM=maternal grandmother MGF=maternal grandfather PGM= paternal grandmother
PGF= paternal grandfather BR=brother SIS=sister S= son D= daughter

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU (Please circle all that apply)
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	M - F - MGM - MGF - PGM - PGF - BR - SIS - S - D

SOCIAL HISTORY (This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.)

Do you smoke? No Yes If yes, what / amount /how long: _____
 Have you ever smoked? No Yes If yes, when did you quit?: _____
 Do you drink alcohol? No Yes If yes, what / amount : _____
 Do you use illegal drugs? No Yes If yes, what / amount : _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis None

REVIEW OF SYSTEMS

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

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
NEUROLOGICAL				EARS, NOSE, MOUTH, THROAT			
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry Throat / Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RESPIRATORY			
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
INTEGUMENTARY (Skin)				Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VASCULAR / CARDIOVASCULAR			
Acne	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rosacea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
EYES				Heart Attack/Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing / Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	GASTROINTESTINAL			
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gritty or Sandy Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	BONES / JOINTS / MUSCLES			
Dry Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle/Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision [with glasses]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	LYMPHATIC / HEMATOLOGIC			
Crossed Eye / Lazy Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding/Clotting Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes of Light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIC / IMMUNOLOGIC			
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Myasthenia Gravis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Surgery [Including LASIK]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC			
Eye Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ENDOCRINE				Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid / Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CONSTITUTIONAL			
GENITOURINARY				Sudden Weight Loss / Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genitals / Kidney / Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain:

Current Medications (INCLUDING eye drops, oral contraceptives, aspirin and over-the-counter products):

Are you allergic to any medications or eye drops? No Yes Please list:

Are you pregnant? No Yes If yes, how far along are you?_____ Due Date: _____

Are you nursing? No Yes

List all major injuries, surgeries and/or hospitalizations you have had:

I declare that the above information is true and accurate:

Signature(Patient, Parent/Guardian)_____

Date_____/_____/_____

Signature(Doctor)_____

Date_____/_____/_____