



HASS VISION CENTER

Date of Exam / /

Name: Last _____ First _____ MI _____ Mr. Mrs. Ms. Miss Dr.
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ *Patient's S.S. #* _____
 Phone # (Home) _____ (Work) _____
 Employer _____ Occupation _____
 Emergency Contact/Telephone no. _____
 Vision Ins. Co. _____ Cont.# _____
 Medical Ins. Co. _____ Cont. # _____
 Date of last eye exam _____ Where _____ Dilated? Y/N
 What is the **BEST TIME** to contact you? _____
 Email: _____ How did you select our office: _____
 Name of Medical Doctor: _____ Last Medical Exam: _____/_____/_____

Medical History

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

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

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: _____

Do you wear glasses? no yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? no yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: Rigid Soft Disposable Other _____ Are they comfortable? yes no

| DISEASE/CONDITION | NO | YES | ? | RELATIONSHIP TO YOU |
|-------------------|----|-----|---|---------------------|
|-------------------|----|-----|---|---------------------|

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| | | | | |
|----------------------------|--------------------------|--------------------------|--------------------------|-------|
| Blindness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cataract | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Crossed Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Macular Degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Retinal Detachment/Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Kidney Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lupus | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | _____ |

Social History This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check box)

Do you drive? no yes If yes, do you have visual difficulty when driving? no yes _If yes, please describe:

Do you use tobacco products? no yes If yes, type/amount/how long: _____

Do you drink alcohol? no yes If yes, type/amount/how long: _____

Do you use illegal drugs? no yes If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

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

| SYSTEM | NO | YES | ? | | NO | YES | ? | |
|---------------------------------|--------------------------|--------------------------|--------------------------|--|----------------------------------|--------------------------|--------------------------|--------------------------|
| CONSTITUTIONAL | | | | | EARS, NOSE, MOUTH, THROAT | | | |
| Fever, Weight Loss/Gain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Allergies/Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| INTEGUMENTARY (Skin) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Sinus Congestion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| NEUROLOGICAL | | | | | Runny Nose | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Post-Nasal Drip | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Chronic Cough | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Dry Throat/Mouth | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| EYES | | | | | RESPIRATORY | | | |
| Loss of Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Blurred Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Distorted Vision/Halos | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Loss of Side Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | VASCULAR/CARDIOVASCULAR | | | |
| Double Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dryness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Heart Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Mucous Discharge | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Redness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Vascular Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sandy or Gritty Feeling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | GASTROINTESTINAL | | | |
| Itching | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Gerd/Acid Reflux | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Burning | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Foreign Body Sensation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Constipation | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Excess Tearing/Watering | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | GENITOURINARY | | | |
| Glare/Light Sensitivity | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Genitals/Kidney/Bladder | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eye Pain or Soreness | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | BONES/JOINTS/MSUCLES | | | |
| Chronic Infection of Eye or Lid | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sties or Chalazion | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Muscle Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Flashes/Floaters in Vision | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Joint Pain | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Tired Eyes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | LYMPHATIC/HEMATOLOGIC | | | |
| ENDOCRINE | | | | | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid/Other Glands | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | Bleeding Problems | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | ALLERGIC/IMMUNOLOGIC | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | PSYCHIATRIC | <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 & list medications:

Doctor's Signature

Date