Welcome to Northview Eye Associates

We are pleased that you have chosen our office for your eye and vision care. You may be assured that every effort will be made to earn your satisfaction. All information is confidential.

CURRENT VISUAL STATUS

Date of Last Eye Exam ______________________
Clinic/Doctor's Name ________________________

Do you wear glasses? yes no

Do you wear contact lenses? yes no
Type/Name _____________ Hours/day ____

Have you ever been diagnosed with:

Cataracts	yes	no
Macular Degeneration	yes	no
Glaucoma	yes	no
Diabetes	yes	no
Dry Eye	yes	no
Eye Infection	yes	no
Floaters/Flashes	yes	no
Iritis/Uveitis	yes	no
Retina Defects	yes	no

EYE AND VISION QUESTIONS

What is the main reason for your visit today?

____
____
____
____
____

PERSONAL MEDICAL HISTORY

Please **circle** if any of the following applies to you. If you have **none** of these conditions, **please circle negative.**

Constitutional	**Negative**
Developmental Disability	Fatigue/Fever
Cancer	Other:

Ear, Nose, Mouth and Throat	**Negative**
Hearing loss	Dry Mouth
Sinusitis	Laryngitis
Other:	

Neurological:	**Negative**
Multiple sclerosis	Stroke/CVA
Epilepsy	Migraines
Autism Spectrum Disorder	Cerebral Palsy
Other:	

Psychiatric:	**Negative**
Anxiety Disorder	Depression
Bipolar Disorder	
ADD/ADHD	
Other:	

Cardiovascular:	**Negative**
Vascular Disease	Hypertension
Stroke/CVA	Heart Disease
Congestive Heart Failure	Other:

Please turn this form over and complete other side

Respiratory: **Negative**
Bronchitis
Asthma
Sleep Apnea
Emphysema
COPD
Other:

Gastrointestinal: **Negative**
Crohn's disease
Colitis
Ulcer
Acid Reflux
Celiac Disease
Other:

Genitourinary: **Negative**
STD-Herpetic/Chlamydia
Prostate Problems
Nursing
Kidney Disease
Pregnant
Other:

Musculoskeletal: **Negative**
Ankylosing Spondylitis
Osteoarthritis
Fibromyalgia
Muscular Dystrophy
Arthritis
Osteoporosis
Gout
Other:

Integumentary: **Negative**
Rosacea
Herpes Simplex
Herpes Zoster/Shingles
Other:
Psoriasis
Eczema

Endocrine: **Negative**
Diabetes Type ___
Hormonal Dysfunction
Thyroid Dysfunction
Other:

Hematologic/Lymphatic: **Negative**
Anemia
Large Volume Blood Loss
Ulcer
High Cholesterol
Leukemia
Other:

Allergic/Immunologic: **Negative**
Drug allergy__________
Environmental Allergy
Rheumatoid Arthritis
Lupus
Sjogren's Syndrome
Other:

MEDICATIONS AND DOSAGES:

____
____
____
____
____
____
____
____
____

Primary Care Provider:
____
____

FAMILY HISTORY

Has anyone in your immediate family been diagnosed with: (if yes, please indicate whom)

Cancer	no	yes _______________
Diabetes	no	yes _______________
Hypertension	no	yes _______________
Thyroid Disease	no	yes _______________
Cataracts	no	yes _______________
Macular Degeneration	no	yes _______________
Glaucoma	no	yes _______________
Strabismus(eye turn)	no	yes _______________
Retinal Detachment	no	yes _______________
Blindness	no	yes _______________

____

Current alcohol use? Yes or No
If yes, how often: ___________

Current tobacco use? Yes or No
If yes, how often: ____________

If so, would you like any information on quitting? Yes or No

Please turn this form over and complete other side