

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.

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**.

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

Constitutional

Developmental Disability
Cancer

Negative

Fatigue/Fever
Other:

Ear, Nose, Mouth and Throat

Hearing loss
Sinusitis
Other:

Negative

Dry Mouth
Laryngitis

Neurological:

Multiple sclerosis
Epilepsy
Autism Spectrum Disorder
Other:

Negative

Stroke/CVA
Migraines
Cerebral Palsy

Psychiatric:

Anxiety Disorder
Bipolar Disorder
Other:

Negative

Depression
ADD/ADHD

Cardiovascular:

Vascular Disease
Stroke/CVA
Congestive Heart Failure

Negative

Hypertension
Heart Disease
Other:

Please turn this form over and complete other side

MEDICATIONS AND DOSAGES:

Respiratory:

Bronchitis
Asthma
Sleep Apnea

Negative

Emphysema
COPD
Other:

Gastrointestinal:

Crohn's disease
Colitis
Ulcer

Negative

Acid Reflux
Celiac Disease
Other:

Genitourinary:

STD-Herpetic/Chlamydia
Prostate Problems
Nursing

Negative

Kidney Disease
Pregnant
Other:

Primary Care Provider:

Musculoskeletal:

Ankylosing Spondylitis
Osteoarthritis
Fibromyalgia
Muscular Dystrophy

Negative

Arthritis
Osteoporosis
Gout
Other:

FAMILY HISTORY

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

Integumentary:

Rosacea
Herpes Simplex
Herpes Zoster/Shingles
Other:

Negative

Psoriasis
Eczema

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	_____

Endocrine:

Diabetes Type ____
Hormonal Dysfunction

Negative

Thyroid Dysfunction
Other:

Hematologic/Lymphatic:

Anemia
Large Volume Blood Loss
Ulcer

Negative

High Cholesterol
Leukemia
Other:

Allergic/Immunologic:

Drug allergy _____
Environmental Allergy
Rheumatoid Arthritis

Negative

Lupus
Sjogren's Syndrome
Other:

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