WEST MILTON
VISION CENTER

Name: _____ **Date:** _____ **Date of Birth:** _____

Occupation: _____ **Email:** _____

Do you wear glasses? Y N Fulltime, distance, or reading only? _____ How long have you had them? _____

Do you wear contact lenses? Y N Soft or Gas Permeable (hard)? _____ Brand: _____
How often do you sleep in them? _____ Hours per day you wear them? _____ Power: R_____ L_____ BC_____
How often do you replace them? _____

Are you interested in contact lenses? Y N

Have you ever been diagnosed with any of the following conditions?

Y N Cataracts
Y N Macular Degeneration
Y N Glaucoma
Y N Diabetic Retinopathy
Y N Dry Eye
Y N Eye Infection/Inflammation/Allergy
Y N Floating Spots/Flashing Lights
Y N Iritis or Uveitis
Y N Retina Defects/Degenerations

Are you having any of the following eye concerns?

Y N Redness
Y N Burning
Y N Itching
Y N Tearing
Y N Discharge
Other: _____

Are you having any of the following vision concerns?

Y N Blurred Vision
Y N Eyestrain
Y N Eye Pain
Y N Severe Light Sensitivity
Y N Headaches
Y N Poor Night Vision
Y N Bothersome Night Glare
Other: _____
Y N Glare/Halos
Y N Double Vision
Y N Total Loss of Vision

Do you experience any problems in the following areas?
(Please include all conditions, even those which are under control with medication.)

Constitution:
Y N Developmental Disability
Y N Cancer (If yes, type: _____)
Y N Fatigue Syndrome

Ear/Nose/Throat:
Y N Hearing Loss
Y N Sinusitis
Y N Dry Mouth

Neurological:
Y N Multiple Sclerosis
Y N Epilepsy
Y N Cerebral Palsy
Y N Tumor
Y N Migraine
Y N Autism Spectrum Disorder

Respiratory:
Y N Cigarette Smoker
Y N Asthma
Y N Bronchitis
Y N Emphysema
Y N Chronic Obstruction
Y N Sleep Apnea

Gastrointestinal:
Y N Colitis
Y N Ulcer
Y N Acid Reflux
Y N Celiac Disease
Y N Crohn's

Integumentary (Skin):
Y N Eczema
Y N Rosacea
Y N Psoriasis
Y N Herpes Simplex/Cold Sores
Y N Herpes Zoster/Shingles

Endocrine
Y N Type 2 Diabetes HbA1C _____
Blood Sugar Range _____ to _____
Y N Type 1 Diabetes _____ HbA1C _____
Blood Sugar Range _____ to _____
Y N Thyroid Dysfunction
Y N Hormonal Dysfunction

Psychiatric:

Y N Depression
Y N Attention Deficit
Y N Anxiety Disorder
Y N Bipolar Disorder

Cardiovascular:

Y N Hypertension
Y N Stroke/CVA
Y N Heart Disease
Y N Vascular Disease
Y N Congestive Heart Failure

Genitourinary:

Y N Kidney Disease
Y N Prostate Disease/Cancer
Y N Benign Prostate Hypertrophy
Y N Pregnant
Y N Nursing
Y N Herpes
Y N Chlamydia

Musculoskeletal:

Y N Osteoarthritis
Y N Arthritis
Y N Fibromyalgia
Y N Muscular Dystrophy
Y N Ankylosing Spondylitis
Y N Osteoporosis
Y N Gout

Hematologic/Lymphatic

Y N Anemia
Y N Large-Volume Blood Loss
Y N Ulcer
Y N High Cholesterol

Allergy/Immunity

Y N Drug Allergies
Y N Environmental Allergies
Y N Rheumatoid Arthritis
Y N Lupus
Y N Sjogren's Syndrome

Other conditions not listed include:

_____
_____
_____

Primary care Physician (First & Last Name): _____

Date of Last Physical Exam: _____

List all medications you take (Including Rx, Over-the-counter, and Eye drops):

_____
_____

List all allergies (Including Drug, Food, and Environmental):

_____

Are you sensitive to latex? Y N
Are You Pregnant? Y N
Are you nursing? Y N
Do you use tobacco? Y N What type? (cigarette, cigar, etc.) _____ How often/much? _____
Do you drink alcohol? Y N How often/much? _____

Do you have an <u>immediate family</u> history of the following? (Include grandparents)
Please list those affected in space provided. (Example, if your mother has had cancer, circle "Y" then writes "mother" on line provided.)

Cancer_____ Y N
Type 1 Diabetes _____ Y N
Type 2 Diabetes _____ Y N
Hypertension _____ Y N
Cataract _____ Y N
Macular Degeneration _____ Y N
Glaucoma _____ Y N
Hyperthyroidism _____ Y N