Vision Source
SIGNATURE EYE CARE

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**REASON FOR TODAY'S VISIT** Please check the box in each row that applies to you and circle the corresponding condition(s) for each.

- ☐ [Routine Visit] [No Eye or Vision Complaints]
- ☐ Blurry Vision: [with Glasses] [with Contacts] [w/out Glasses] [w/out Contacts] [at Distance] [at Near] [at Computer]
- ☐ Need Updated Prescription: [Glasses] [Contacts] [Safety Glasses] [Sunglasses]
- ☐ Eye Irritation: [Dry Eyes] [Burning] [Itching] [Redness] [Watering] [Discharge] [Mattering] [Eye Pain]
- ☐ Eye Related Discomfort: [Eye Strain] [Eye Fatigue] [Double Vision] [Headaches] [Migraines] [Ocular Migraines]
- ☐ [Glare] [Decreased Night Vision] [Light Sensitivity]
- ☐ Sudden Vision Changes: [Sudden Loss of Vision] [Visual Distortions] [Flashes of Light] [Missing Spots in Vision]
- ☐ Other ______

Do you wear glasses? ☐ Yes [All the Time] [Distance Only] [Near Only] [Computer Only] ☐ No [Never worn] [Have in past]
Do you wear contacts? ☐ Yes [Soft lenses] [Dailies] [Monthly] [Two-Week] [Hard/GP lenses] ☐ No [Never worn] [Have in past]
If no, are you interested in trying contacts today? ☐ Yes ☐ No

Please list any medication or latex allergies ______

Please list all current medications (including prescribed, OTC, EYE DROPS, vitamin/supplement, oral/IUD/implant birth control): ______

**REVIEW OF SYSTEMS/MEDICAL/FAMILY HISTORY** Please indicate all of the following condition(s) that apply to **YOU** by filling in the ☐, a **FAMILY MEMBER** by filling in the ○, or **BOTH** by filling in both.

| | | | | | |
|---|---|---|---|---|---|
| **Constitutional:** | ☐ ○ Cancer (type) ______ | | | | |
| **ENT:** | ☐ ○ Hearing Loss | ☐ ○ Sinus Issues | ☐ ○ Dry Mouth | | |
| **Neuro:** | ☐ ○ Epilepsy | ☐ ○ Migraines | ☐ ○ Multiple Sclerosis | ☐ ○ Cerebral Palsy | ☐ ○ Autism |
| **Psych:** | ☐ ○ ADD/ADHD | ☐ ○ Anxiety | ☐ ○ Depression | ☐ ○ Bipolar Disorder | |
| **Cardiovascular:** | ☐ ○ High Blood Pressure | ☐ ○ Heart Disease | ☐ ○ CHF | ☐ ○ Stroke | |
| **Respiratory:** | ☐ ○ COPD | ☐ ○ Asthma | ☐ ○ Emphysema | ☐ ○ Sleep Apnea | |
| **GI:** | ☐ ○ Crohn's | ☐ ○ Ulcerative Colitis | ☐ ○ Celiac Disease | | |
| **Genitourinary:** | ☐ ○ Kidney Disease | ☐ ○ Prostate Cancer | ☐ ○ BPH | ☐ ○ STD (type) ______ | |
| **Musculoskeletal:** | ☐ ○ Arthritis | ☐ ○ Osteoporosis | ☐ ○ Fibromyalgia | ☐ ○ Ankylosing Spon | ☐ ○ Gout |
| **Integumentary:** | ☐ ○ Eczema | ☐ ○ Rosacea | ☐ ○ Cold Sores | ☐ ○ Shingles | |
| **Endocrine:** | ☐ ○ Diabetes 1 / 2 | ☐ ○ Thyroid Hypo/Hyper | ☐ ○ Hormone Imbalance | | |
| **Heme/Lymph:** | ☐ ○ Anemia | ☐ ○ High Cholesterol | ☐ ○ Clotting Disorder | ☐ ○ Vascular Disorder | |
| **Autoimmune/Inflamm:** | ☐ ○ Lupus | ☐ ○ Sjogren's | ☐ ○ Sarcoidosis | ☐ ○ Rheumatoid Arthritis | |
| **Other:** | ☐ ○ ______ | | | | |

**OCULAR HISTORY/FAMILY OCULAR HISTORY**

- ☐ ○ Glaucoma
- ☐ ○ Cataract
- ☐ ○ Macular Degeneration
- ☐ ○ Strabismus (eye turn)
- ☐ ○ Amblyopia (lazy eye)
- ☐ ○ Eye Patching / Vision Therapy
- ☐ ○ Retinal Disease/Disorder/Detachment
- ☐ ○ Eye Injury/Trauma
- ☐ ○ Dry Eyes
- ☐ ○ Blindness
- ☐ ○ Other ______

Have you had any of the following eye surgeries? ☐ Lasik/PRK ☐ Cataract Surgery ☐ Muscle Realignment ☐ Glaucoma Surgery
Please list any non-eye related surgeries you have had ______
Do you currently use any of the following? ☐ Tobacco ☐ Alcohol ☐ Recreational Drugs ☐ None
How many hrs/day are you on a computer/tablet? ☐ None ☐ 1-3hr ☐ 4-6hr ☐ 7-9hr ☐ 9+hr
Are you currently pregnant or nursing? ☐ No ☐ Pregnant ☐ Nursing

Occupation ______ Hobbies ______

Current Height ______ Current Weight ______