Name: ____ Date: _____________________
E-Mail Address _______________________________________

Optomap retinal imaging is an essential component of comprehensive eye care. *This test will be performed today if you are here for your annual eye exam.* The maximum fee to you is capped at $41.00. If your vision/health plan provides partial or full coverage we will apply it. **Initial here:** __________

When was your last physical exam (including blood work)? ___________________ HbA1c ___________
Name of Primary Care Physician:_____________ Phone Number:_____________ Address: __________________
Your Current: **Height** ___________ **Weight** ___________
When was your last comprehensive eye exam? _________________________________

RACE
◯ American Indian or Alaska Native
◯ Asian
◯ Black or African American
◯ Hispanic or Latino
◯ Native Hawaiian or other Pacific Islander
◯ White
◯ Decline to specify

ETHNICITY
◯ Hispanic
◯ Non-Hispanic
◯ Decline to specify

What is your preferred language?
◯ English ◯ Spanish ◯ Chinese ◯ French ◯ Italian ◯ Russian ◯ Portuguese ◯ Other_______
Occupation: ____________________ How many years? _______ Employer: _______________________

Social History
Do you drink alcohol? ◯ No ◯ Occasional ◯ 1 Per day ◯ 2-3 Per day ◯ 4+ Per day
Smoking status: ◯ Non ◯ Current ◯ Light smoker ◯ Moderate smoker ◯ Heavy smoker
Former smoker: When did you quit smoking? _______________ Do you chew tobacco? ◯ No ◯ Yes
Do you use engage in regular exercise? ◯ No ◯ Yes
Do you use nutritional supplements? ◯ No ◯ Yes
Hobbies / Interest:____

Visual History
Computer used? ◯ No ◯ Yes How many hours/day? ______ Distance in inches from computer? _____
Do you drive? ◯ No ◯ Yes Daily mileage? ___________
Do you have glare problems? ◯ No ◯ Yes
Do you have visual difficulty when driving? ◯ No ◯ Yes
Do you have problems with night vision? ◯ No ◯ Yes

Glasses
Do you currently wear glasses? ◯ No ◯ Yes Since: ________________
Type of glasses: ◯ Full Time ◯ Part Time ◯ Distance ◯ Close Up/Reading
Glasses Owned: ◯ Single Vision ◯ Bifocals ◯ Trifocals ◯ Backup ◯ Safety ◯ Sports ◯ Progressive
Have you had trouble in the past with glasses? ◯ No ◯ Yes _______________________________
Do you wear sunglasses? ◯ No ◯ Yes Are your sunglasses your current prescription? ◯ No ◯ Yes

Contact Lens History
Have you ever tried to wear contact lenses? ◯ No ◯ Yes Reason for stopping? ________________
If you are not a contact lens wearer, are you interested in trying contacts at this time? ◯ No ◯ Yes
Do you currently wear contact lenses? ◯ No ◯ Yes Since: ________________
Type and brand of contacts: ____
How many hours per day? ______ How many days per week? ______ How long today? _______
Cleaner: _______________ Disinfectant: __________________ Enzyme: __________________

TURN OVER FOR BACK SIDE

Medication
List any drug allergies: ____
List allergic reaction: ____

List current medications/dosage:
____
____
____

Past surgeries/dates/surgeon:
____
____

Eye Disease
◯ Amblyopia (lazy eye)
◯ Blepharitis
◯ Blindness
◯ Cataract
◯ Color Blindness
◯ Diabetic Retinopathy
◯ Dry Eye Syndrome
◯ Eye Injuries
◯ Glaucoma
◯ Glaucoma Suspect
◯ High Risk Medication
◯ Macular Degeneration
◯ PVD
◯ Retinal Detachment
◯ Strabismus (eye turn)
◯ Other

Current Eye Symptoms
◯ Glare Sensitivity
◯ Headaches
◯ Light Sensitivity
◯ Tired Eyes
◯ Burning
◯ Dryness
◯ Epiphora
◯ Eyelid Swelling
◯ Eye Pain/Soreness
◯ Foreign Body Sensation
◯ Infection of Eye Lid
◯ Itching
◯ Mucus
◯ Ptosis (drooping eyelid)
◯ Redness
◯ Sandy or Gritty Feeling
◯ Other

Visual Symptoms
◯ Blurred Vision Distance
◯ Blurred Vision Near
◯ Distorted Vision
◯ Double Vision
◯ Flashes of Light
◯ Floaters or Spots
◯ Fluctuating Vision
◯ Loss of Central Vision
◯ Loss of Side Vision
◯ Loss of Vision
◯ Other

Review of Symptoms
◯ Constitutional Symptoms (fever, weight loss, etc.)
◯ Ears, Nose, Throat
◯ Cardiovascular (heart, hypertension)
◯ Respiratory (asthma, emphysema, etc.)
◯ Gastrointestinal
◯ Genital, Kidney, Bladder
◯ Muscles, Bones, Joints (arthritis, etc.)
◯ Skin (acne, skin cancer, etc.)
◯ Neurological (multiple sclerosis, etc.)
◯ Psychiatric (anxiety, depression, etc.)
◯ Endocrine (diabetic, hypothyroid, etc.)
◯ Blood/Lymph (anemic, cholesterol, etc.)
◯ Allergic/Immunologic (seasonal allergies, lupus, etc.)
◯ Pregnant
◯ Nursing

Family History (indicate father, mother, ***paternal/maternal*** grandmother, *paternal/maternal* grandfather, etc.)
◯ Amblyopia (lazy eye) ________
◯ Blindness ________
◯ Cataract ________
◯ Color Blindness ________
◯ Eye Tumor ________
◯ Glaucoma ________
◯ Glaucoma Suspect ________
◯ Macular Degeneration ________
◯ Retinal Detachment _________
◯ Strabismus (eye turn) _________
◯ Arthritis _________
◯ Cancer _________
◯ Diabetes _________
◯ Heart Disease _________
◯ High Blood Pressure _________
◯ Kidney Disease _________
◯ Lupus _________
◯ Stroke _________
◯ Thyroid Disease _________
◯ Other Disease _________
◯ Other __________________