## Welcome to Dolan Family Vision

## Doug Dolan, Optometrist

### Patient Information

Name: _____ Today's Date: ____-____-____

Mailing Add: _____ Home Phone: ( ) ____-_____

City: _____ State: ___ Zip: _____ Work Phone: ( ) ____-_____

Birth Date: ____-____-____ ( Male Female ) Last Eye Exam: ____-____-____

Primary Doctor: _____ Last Medical Exam: ____-____-____

Responsible Party: _____ Employer: _____

Insurance: _____

**How did you hear of our office?**
- ☐ Recall Card
- ☐ Previous Patient
- ☐ Phone Book
- ☐ Insurance Listing
- ☐Other: _____
- ☐ Whom may we thank for referring you? _____

### Medical History

Do you have any allergies to medications? Yes No If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):_____

_____

_____

Are you pregnant and/or nursing? Yes No

### Do you …

**Wear Glasses?**
- ☐ Yes
- ☐ How long? ___
- ☐ No
- ☐ Used to wear

**When worn?**
- ☐ Full time
- ☐ Part time
- ☐ Distance Only
- ☐ Reading Only
- ☐ Multifocal
- ☐ Have, but don't

**Wear Contacts?**
- ☐ Want
- ☐ No
- ☐ Yes
- ☐ Used to wear

**Contact Type?**
- ☐ Soft
- ☐ Hard / RGP
- ☐ Bifocals
- ☐ Extended Wear
- ☐ Toric/Astigmatic

**Have Vision / Eye Problems?**
- ☐ Cataract
- ☐ Glaucoma
- ☐ Iritis
- ☐ Blindness
- ☐ Color Blindness
- ☐ Motion Sickness
- ☐ Eye Surgery
- ☐ Crossed Eyes
- ☐ Macular Degeneration

**Participate in Recreational Activities**
- ☐ Reading
- ☐ Computers
- ☐ Sewing/Crafts
- ☐ Music/Piano
- ☐ Hunting/Shooting
- ☐ Fishing
- ☐ Golf
- ☐ Skiing
- ☐ Flying
- ☐ Home Workshop

- ☐ Work at a computer for long
- ☐ Have more than one pair of glasses?
- ☐ Want thinner, lighter lenses?
- ☐ Wear bifocals?
  - ☐ Are you bothered by head tilting
  - ☐ Restricted areas of vision
- ☐ Have any times you would rather not wear glasses?
- ☐ How much time do you spend on outdoor activities?_____
- ☐ Have prescription sunglasses?
- ☐ Notice glare or reflection particularly when driving at night?
- ☐ Have family members in need of eyecare?_____

### Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

| DISEASE /CONDITION | YES | NO | ? | RELATIONSHIP TO YOU (**S**=Self **P**=Parent **GP**=Grandparent **SIB**=Sibling **C**=Child) |
|---|---|---|---|---|
| Blindness | ☐ | ☐ | ☐ | _____ |
| Cataract | ☐ | ☐ | ☐ | _____ |
| Glaucoma | ☐ | ☐ | ☐ | _____ |
| Macular Degeneration | ☐ | ☐ | ☐ | _____ |
| Retinal Detachment/Disease | ☐ | ☐ | ☐ | _____ |
| Arthritis | ☐ | ☐ | ☐ | _____ |
| Cancer | ☐ | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | ☐ | _____ |
| High Blood Pressure | ☐ | ☐ | ☐ | _____ |
| Kidney Disease | ☐ | ☐ | ☐ | _____ |
| Lupus | ☐ | ☐ | ☐ | _____ |
| Thyroid Disease | ☐ | ☐ | ☐ | _____ |
| Other _____ | | | | _____ |

## Social History

Note: This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. (some insurance companies require this information)

☐ Yes, I would prefer to discus my Social History information directly with my doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, please describe:_____

_____

Do you use tobacco products? Yes No If yes, type/amount/how long:_____

Do you drink alcohol? Yes No If yes, type/amount/how long:_____

Do you use illegal drugs? Yes No If yes, type/amount/how long:_____

Have you ever been exposed or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ HIV ☐ Syphilis

## Review of Systems (do you currently, or have you ever had any problems in the following areas)

| SYSTEM | YES | NO | ? |
|---|---|---|---|
| **CONSTITUTIONAL** | | | |
| Fever, Weight Loss / Gain | ☐ | ☐ | ☐ |
| **INTEGUMENTARY** (skin) | ☐ | ☐ | ☐ |
| **NEUROLOGICAL** | | | |
| Headaches | ☐ | ☐ | ☐ |
| Migraines | ☐ | ☐ | ☐ |
| Seizures | ☐ | ☐ | ☐ |
| MS | ☐ | ☐ | ☐ |
| **EYES** | | | |
| Loss of Vision | ☐ | ☐ | ☐ |
| Blurred Vision | ☐ | ☐ | ☐ |
| Distorted Vision / Halos | ☐ | ☐ | ☐ |
| Loss of Side Vision | ☐ | ☐ | ☐ |
| Double Vision | ☐ | ☐ | ☐ |
| Dryness | ☐ | ☐ | ☐ |
| Mucous Discharge | ☐ | ☐ | ☐ |
| Redness | ☐ | ☐ | ☐ |
| Sandy or Gritty Feeling | ☐ | ☐ | ☐ |
| Itching | ☐ | ☐ | ☐ |
| Burning | ☐ | ☐ | ☐ |
| Excess Tearing / Watering | ☐ | ☐ | ☐ |
| Glare / Light Sensitivity | ☐ | ☐ | ☐ |
| Eye Pain or Soreness | ☐ | ☐ | ☐ |
| Chronic Infection of Eye or Lid | ☐ | ☐ | ☐ |
| Styes or Chalazion | ☐ | ☐ | ☐ |
| Flashes / Floaters in Vision | ☐ | ☐ | ☐ |
| Tired Eyes | ☐ | ☐ | ☐ |
| **ENDOCRINE** | | | |
| Thyroid / Other Glands | ☐ | ☐ | ☐ |

| | YES | NO | ? |
|---|---|---|---|
| **EARS, NOSE, MOUTH, THROAT** | | | |
| Allergies / Hay Fever | ☐ | ☐ | ☐ |
| Sinus Congestion | ☐ | ☐ | ☐ |
| Runny Nose | ☐ | ☐ | ☐ |
| Post-Nasal Drip | ☐ | ☐ | ☐ |
| Chronic Cough | ☐ | ☐ | ☐ |
| Dry Throat / Mouth | ☐ | ☐ | ☐ |
| **RESPIRATORY** | | | |
| Asthma | ☐ | ☐ | ☐ |
| Chronic Bronchitis | ☐ | ☐ | ☐ |
| Emphysema | ☐ | ☐ | ☐ |
| **VASCULAR / CARDIOVASCULAR** | | | |
| Diabetes | ☐ | ☐ | ☐ |
| Heart Pain | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ |
| Vascular Disease | ☐ | ☐ | ☐ |
| **GASTROINTESTINAL** | | | |
| Chronic Diarrhea | ☐ | ☐ | ☐ |
| Constipation | ☐ | ☐ | ☐ |
| **GENITOURINARY** | | | |
| Genital / Kidney / Bladder | ☐ | ☐ | ☐ |
| **BONES / JOINTS / MUSCLES** | | | |
| Rheumatoid Arthritis | ☐ | ☐ | ☐ |
| Muscle Pain | ☐ | ☐ | ☐ |
| Joint Pain | ☐ | ☐ | ☐ |
| **LYMPHATIC / HEMATOLOGIC** | | | |
| Anemia | ☐ | ☐ | ☐ |
| Bleeding Problems | ☐ | ☐ | ☐ |
| **ALLERGIC / IMMUNOLOGIC** | ☐ | ☐ | ☐ |
| **PSYCHIATRIC** | ☐ | ☐ | ☐ |

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

_____

_____

**I acknowledge that I have received the *Notice of Privacy Practices* from Dolan Family Vision**, and am also aware that should my account require legal collection services that I am responsible for all attorney, court, and/or collection fees.

Patient's Signature: _____ Date: ____-____-____

Doctor's Signature: _____ Date: ____-____-____