Welcome to Great Lakes Vision Care

Last Name________________________ First Name_________________ MI____ DOB:___/___/______

M or F SSN:____/___/______ Marital Status: Single / Married / Divorced / Widowed

Address: ______________________________ City: _________________ State:______ Zip:_________

Home Ph:( )_____________ Work Ph:( )___________ Ext: ____ Cell Ph:( )_____________

E-mail Address:_________________________ Preferred Contact: Cell / Home / Text / E-mail / U.S. Mail

Primary Care Physician: ________________________ **Height**:____ **Weight:**____ Birth State:___

Race: White/Caucasian, American Indian/ Alaska Native, Black/ African American, Native Hawaiian/ Pacific Islander, Other Race
Ethnicity: Not Hispanic or Latino, Hispanic or Latino, Unknown

Employer/School: ________________________ Occupation/ School Grade: __________________________

Sports/Hobbies:___________________________ Mother's Maiden Name: _________________________

Emergency Contact:____________________________ Relation:_____________ Phone #:( )_____-_______

Minors Only:
Mother's Name: ____ SSN:_______/_____/________

Father's Name: ____ SSN:_______/_____/________

How did you hear about our office? ____

Date of Last Eye Exam:_____/___/______ Clinic/Eye Doctor's Name:_________________________________

Do you wear glasses? Yes / No (All the time / Sometimes / Work only / Reading only / Driving only)

How old are your present glasses? ________ years Do you wear prescription Sun Wear? Yes / No

Are you interested in contacts? Yes / No Do you wear contacts? Yes / No Type:______________________

Solution Used:____________ Wear Time: Daily / Overnight Replacement Schedule: Daily / 2 wk / Monthly

Are you interested in LASIK? Yes / No Have you ever had an eye injury? No / Yes: Right / Left

Have you ever had eye surgeries? No / Yes: Why?____

Have you used eye medication? No / Yes: Why?____

Have you ever been diagnosed with?
Cataracts: No / Yes: When were you diagnosed? ____
Glaucoma: No / Yes: When were you diagnosed? ____
Macular Degeneration: No / Yes: When were you diagnosed?____

What are your visual symptoms today: Please circle any that apply:

Please indicate Right, Left, or Both, along with severity 1(Low) 2(Moderate) 3(High)

[ ]Blurred Vision/Distance R L B
[ ]Blurred Vision/Near R L B
[ ]Double Vision R L B
[ ]Eye Strain R L B
[ ]Eye Infections R L B
[ ]Eye Pain/Soreness R L B
[ ]Tired Eyes R L B
[ ]Burning Eyes R L B
[ ]Itchy Eyes R L B
[ ]Dry Eyes R L B
[ ]Red Eyes R L B
[ ]Watery Eyes R L B
[ ]Wandering Eye R L B
[ ]Mucus Discharge R L B
[ ]Floaters or Spots R L B
[ ]See Flashes R L B
[ ]See Halos R L B
[ ]Poor Night Vision R L B
[ ]Headaches R L B
[ ]Migraine Headaches R L B
[ ]Loss of Vision R L B
[ ]Crossed Eyes R L B
[ ]Light Sensitive R L B
[ ]Gritty Feeling R L B
[ ]Poor Color Vision R L B
[ ]Droopy Lid R L B

*****Please turn over and complete other side*****

PERSONAL MEDICAL HISTORY: PLEASE CHECK ANY OF THE FOLLOWING THAT **APPLIES** TO YOU, AND LIST ANY MEDICATION BELOW FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __None __Stroke __Heart Disease __High Blood Pressure __ Cholesterol	Endocrine: __None __Hypothyroid __Hyperthyroid __Other	Respiratory: __None __Asthma __COPD __Bronchitis __Other
Genitourinary: __None __Pregnancy __STDs __Prostate Disorder __Other	**Diabetics:** Type I/ Type II _None __Borderline # yrs _____ A1c ___ Fingerstick _____	Psychiatric: __None __ADHD __Schizophrenia __Depression __Other
Neurological: __None __Epilepsy __MS __MD __Other	Musculoskeletal: __None __Arthritis __Osteoporosis __Fibromyalgia __Other	Immunologic: __None __AIDS __Lupus __RA __Other
Hematological: __None __Anemia __Leukemia __Cancer __Other	Gastrointestinal: __None __Crohn’s __Acid Reflux __Colitis __Other	Ear/Nose/Throat: __None __Hearing Loss __Sinusitis __Trauma __Other
Dermatologic: __None __Eczema __Rosacea __Psoriasis __Other	Ocular: __None __Glaucoma __ARMD __Detached Retina __Other	Females: Pregnant Yes / No Nursing Yes / No

Alcohol Use: Yes / No Frequency: Daily / Social Tobacco Use: Yes / No Current / Former / Never

Allergies:
Environmental allergies: ____ __None
Medication allergies: ____ __None

Please list any medications and/or drugs that you are taking (including vitamins/ herbal):
See Attached List: ____

1		For:	4		For:
2		For:	5		For:
3		For:	6		For:

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

Retinal Detachment:	Y / N		Blindness:	Y / N	
High Blood Pressure:	Y / N		Cataracts:	Y / N	
Diabetes:	Y / N		Glaucoma:	Y / N	
Cancer:	Y / N		Crossed Eyes:	Y / N	
Heart Disease:	Y / N		Macular Degeneration:	Y / N	
Thyroid Disease:	Y / N		Lupus	Y / N	

Reviewed by: Dr____ Date:__________________