WELCOME TO OUR OFFICE

Odom's Eye Care, PLLC

Today's Date _____ Date of Last Eye Exam _____ Reason for visit _____

Name _____ DOB _____ Age _____ □ Male □ Female
First Middle Last

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ Social Security #_____

Employer or School _____ Occupation _____ E-mail _____

INSURANCE

Vision Insurance _____

Insured Name _____ DOB _____

ID# _____ SS# _____

Medical Insurance _____

Insured Name _____ DOB _____

ID# _____ SS# _____

QUESTIONNAIRE

Current medications (Rx or Over the Counter)

			Name of Medication
Antihistamines	Y	N	_____
Diuretics (fluid pills)	Y	N	_____
Blood Pressure Pills	Y	N	_____
Oral Contraceptives	Y	N	_____
Sleeping Tablets	Y	N	_____
Diabetic Medications	Y	N	_____
Heart Medications	Y	N	_____
Eye Drops	Y	N	_____
Other	Y	N	_____

Allergies: _____

Family Medical History

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

Other _____

_____

Do you...

Work at a computer for long periods?	Y	N
Have more than one pair of glasses?	Y	N
Want information on thinner, lighter lenses?	Y	N
Wear Bifocals?	Y	N
(If yes, are you bothered by head tilting, restricted areas of vision correction, etc.?)	Y	N
Always like to wear your glasses?	Y	N
Spend time outdoors? (how much) _____hrs. /week	Y	N
Have prescription sunglasses?	Y	N
Have problems with glare or reflection particularly when driving at night?	Y	N
Have you ever worn/are currently wearing contacts?	Y	N
Are you planning on getting new contacts today?	Y	N
Are you planning on getting new glasses today?	Y	N
Would you like information on Lasik Correction?	Y	N
Are you interested in having Lasik Correction?	Y	N

Social History

Do you use tobacco products?	Yes	No
Do you use alcohol?	Yes	No
Do you use illegal drugs?	Yes	No

Have you ever been exposed to or infected with: (circle)
Hepatitis HIV Syphilis Gonorrhea

☐I wish to discuss my social history with the doctor. (check box)

How did you hear about us? _____

Please turn form over and complete side two

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	☐	☐	☐
EYES			
Loss of Vision	☐	☐	☐
Distorted Vision/Halos	☐	☐	☐
Double Vision	☐	☐	☐
Dryness	☐	☐	☐
Mucous Discharge	☐	☐	☐
Redness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Excess Tearing/Watering	☐	☐	☐
Glare/Light Sensitivity	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Chronic Infection of Eye or Lid	☐	☐	☐
Sites of 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	☐	☐	☐
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
VASCULAR/CARDIOVASCULAR	☐	☐	☐
Diabetes	☐	☐	☐
Heart Pain	☐	☐	☐
High Blood Pressure	☐	☐	☐
Vascular Disease	☐	☐	☐
GASTROINTESTINAL	☐	☐	☐
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
Genitourinary	☐	☐	☐
Genitals/Kidney/Bladder	☐	☐	☐
BONES/JOINT/MUSCLES ☐	☐	☐	
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / HEMATOLOGIC	☐	☐	☐
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
ALLERGIC / IMMUNOLOGIC	☐	☐	☐

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

_____

_____ _____

Doctor Signature **Date**

Date	Dr. Initials	Tech Initials	Patient History Changes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____