



WELCOME TO NORTHERN VIRGINIA DOCTORS OF OPTOMETRY

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____

Preferred Language: English Spanish

Race: American Indian or Alaskan Native Black or African American Asian
Native Hawaiian/ Other Pacific Islander Hispanic White

PERSONAL EYE INFORMATION

We would like to thank the person who referred you to our office: How did you hear about us?

Yellow pages Insurance Google Friend/ Co-worker/ Family: Name: _____

Other: _____

Date of Last Eye Examination: _____ Doctor's Name: _____

So we may better serve your vision needs, please complete the questions below regarding your visit to our office:

- Do you work on a computer? If so, how many hours a day? _____

Your reason(s) for visiting our office today: (please check all applicable items)

<input type="checkbox"/> General check up	<input type="checkbox"/> Headaches	<input type="checkbox"/> Want contact lenses
<input type="checkbox"/> Laser vision consultation	<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Standard soft
<input type="checkbox"/> Lost or broken glasses	<input type="checkbox"/> Eyes water	<input type="checkbox"/> Disposable
<input type="checkbox"/> Want new eyeglasses	<input type="checkbox"/> Eyes itch	<input type="checkbox"/> Tinted/ colored
<input type="checkbox"/> Blurred distance vision	<input type="checkbox"/> Eyes feel dry	<input type="checkbox"/> Bifocal/ Multifocal
<input type="checkbox"/> Blurred intermediate vision	<input type="checkbox"/> Pain in eyes	<input type="checkbox"/> Gas permeable
<input type="checkbox"/> Blurred near vision	<input type="checkbox"/> Flashes of lights	<input type="checkbox"/> Other _____
<input type="checkbox"/> Night vision problems	<input type="checkbox"/> Floating spots in vision	_____
<input type="checkbox"/> Double vision	<input type="checkbox"/> Eyes feel tired	_____

Contact Lens Questionnaire:

- Are you wearing contact lenses today? ___ Yes ___ No
- If yes, what type? ___ Soft ___ Rigid/ Gas Permeable
- What type of solution do you use to clean and disinfect: _____
- Have your worn contact lenses in the past? If so, please tell us why you quit _____

Please mark those activities in which you participate:

<input type="checkbox"/> Tennis	<input type="checkbox"/> Basketball	<input type="checkbox"/> Skiing	<input type="checkbox"/> Football	<input type="checkbox"/> Dancing	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Soccer	<input type="checkbox"/> Swimming	<input type="checkbox"/> Hunting	<input type="checkbox"/> Fishing	<input type="checkbox"/> Golf	<input type="checkbox"/> Rollerblading
<input type="checkbox"/> Biking	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Walking	<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Reading	<input type="checkbox"/> Baseball
<input type="checkbox"/> Gardening	<input type="checkbox"/> Crafts	<input type="checkbox"/> Jogging	<input type="checkbox"/> Sewing	<input type="checkbox"/> Aerobics	<input type="checkbox"/> Musical Instrument

SOCIAL HISTORY

- Do you drive? ___ YES ___ NO
- If yes, do you have visual difficulty when driving? ___ NO ___ YES (describe) _____
- Have you ever used tobacco products? ___ NO ___ YES If yes, type/amount/how long: _____
- Do you drink alcohol? ___ NO ___ YES If yes, type/amount/how long: _____
- Do you use illegal drugs? ___ NO ___ YES If yes, type/amount/how long: _____

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

Patient name: _____ DOB: _____

FAMILY HISTORY	YES	WHO? (BLOOD RELATIVES ONLY)		YES	WHO?
ARTHRITIS			BLINDNESS		
CANCER			CATARACTS		
DIABETES			CROSSED EYES		
HEART DISEASE			GLAUCOMA		
HIGH BLOOD PRESSURE			MACULAR DEGENERATION		
HIGH CHOLESTEROL			RETINAL DETACHMENT/ DISEASE		
KIDNEY DISEASE					
LUPUS					
THYROID DISEASE					
LUNG DISEASE					

PERSONAL MEDICAL HISTORY **Date of Last Medical Exam:** _____
Name of Medical Doctor: _____ **Doctor's Phone #:** _____
List any **MEDICATIONS** you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____

Do you have any **ALLERGIES** to medications? NO YES please list _____

List all major surgeries, injuries and/ or hospitalizations you have had: _____

GENERAL HEALTH	ENDOCRINE	SKIN
Height:	<input type="checkbox"/> None	<input type="checkbox"/> None
Weight:	<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Eczema
<input type="checkbox"/> <input type="checkbox"/> None	When diagnosed:	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Weight loss/ gain:	Last HbA1c	<input type="checkbox"/> Other
<input type="checkbox"/> Fever	<input type="checkbox"/> Thyroid (specify):	MUSCLE/ SKELETAL
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Other	<input type="checkbox"/> None
<input type="checkbox"/> Pregnant	GASTROINTESTINAL	<input type="checkbox"/> Arthritis:
<input type="checkbox"/> Breast-feeding	<input type="checkbox"/> None	Type:
<input type="checkbox"/> <input type="checkbox"/> Trauma	<input type="checkbox"/> <input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> <input type="checkbox"/> Other	<input type="checkbox"/> Colitis	<input type="checkbox"/> <input type="checkbox"/> Ankylosing Spondylitis
OCULAR	<input type="checkbox"/> Acid reflux/ ulcer	<input type="checkbox"/> Other
<input type="checkbox"/> <input type="checkbox"/> Blindness	<input type="checkbox"/> Hepatitis	NEUROLOGICAL
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Other	<input type="checkbox"/> None
<input type="checkbox"/> Glaucoma	GENITAL/ URINARY	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> <input type="checkbox"/> Macular degeneration	<input type="checkbox"/> None	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Retinal condition	<input type="checkbox"/> Urinary Tract Infection	<input type="checkbox"/> Tremors
<input type="checkbox"/> <input type="checkbox"/> Other	<input type="checkbox"/> Herpes	<input type="checkbox"/> <input type="checkbox"/> Other
ALLERGIC/IMMUNOLOGIC	<input type="checkbox"/> Chlamydia	PSYCHIATRIC
<input type="checkbox"/> None	<input type="checkbox"/> Syphilis	<input type="checkbox"/> None
<input type="checkbox"/> Lupus (SLE)	<input type="checkbox"/> Other	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Rheumatoid Arthritis	EARS, NOSE, THROAT	<input type="checkbox"/> Depression
<input type="checkbox"/> <input type="checkbox"/> Environmental Allergies	<input type="checkbox"/> None	<input type="checkbox"/> <input type="checkbox"/> Bipolar
<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Runny Nose, Post Nasal Drip	<input type="checkbox"/> <input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Other	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Other
CARDIOVASCULAR	<input type="checkbox"/> Upper Respiratory Infection	RESPIRATORY
<input type="checkbox"/> None	<input type="checkbox"/> Other	<input type="checkbox"/> None
<input type="checkbox"/> High Blood Pressure	HEMATOLOGIC/ LYMPHATIC	<input type="checkbox"/> Asthma
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> None	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> Vascular disease	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Other
<input type="checkbox"/> Other	<input type="checkbox"/> <input type="checkbox"/> Bleeding Disorder	
	<input type="checkbox"/> Other	

Patient Signature: _____ **Date:** _____

Doctor Reviewed: _____ **Date:** _____