WELCOME TO NORTHERN VIRGINIA DOCTORS OF OPTOMETRY

TODAY'S DATE:_____

PATIENT NAME:_____**DOB:**_____

PERSONAL EYE INFORMATION

We would like to thank the person who referred you to our office: How did you hear about us? (friend, co-worker, family, yellow pages, insurance, etc.)_____

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)

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

___ Tennis	___ Basketball	___ Skiing	___ Football	___ Dancing	___ Woodworking
___ Soccer	___ Swimming	___ Hunting	___ Fishing	___ Golf	___ Rollerblading
___ Biking	___ Racquetball	___ Walking	___ Scuba Diving	___ Reading	___ Baseball
___ Gardening	___ Crafts	___ Jogging	___ Sewing	___ Aerobics	___ Musical Instrument

SOCIAL HISTORY

- Do you drive? ___ YES ___ NO
- If yes, do you have visual difficulty when driving? ___ NO ___ YES (describe)_____
- Do you use 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					

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	ENDROCRINE	SKIN
Height:	___None	___None
Weight:	___Diabetes ___Type I ___Type II	___Eczema
___None	When diagnosed:	___Rosacea
___Weight loss/gain	Last HbA1c	___Other
___Fever	___Thyroid (specify)	**MUSCLE/SKELETAL**
___Fatigue	___Other	___None
___Pregnant	**GASTROINTESTINAL**	___Arthritis
___Breast Feeding	___None	Type:
___Trauma	___Crohn's Disease	___Fibromyalgia
___Other	___Colitis	___Anklosing Spondylitis
OCULAR	___Acid reflux/ulcer	___Other
___Blindness	___Hepatitis	**NEUROLOGICAL**
___Cataracts	___Other	___None
___Glaucoma	**GENITAL/URINARY**	___Multiple Sclerosis
___Macular Degeneration	___None	___Epilepsy
___Retinal Condition	___Urinary Tract Infection	___Tremors
___Other	___Herpes	___Other
ALLERGIC/IMMUNOLOGIC	___Chlamydia	**PSYCHIATRIC**
___None	___Syphilis	___None
___Lupus (SLE)	___Other	___Anxiety
___Rheumatoid Arthritis	**EARS, NOSE, THROAT**	___Depression
___Environmental Allergies	___None	___Bipolar
___HIV Positive	___Runny Nose, Post Nasal Drip	___Schizophrenia
___Other	___Sinusitis	___Other
CARDIOVASCULAR	___Upper Respiratory Infection	**RESPIRATORY**
___None	___Other	___None
___High Blood Pressure	**HEMATOLOGIC LYMPHATIC**	___Asthma
___Heart Disease	___None	___Bronchitis
___Cholesterol	___Anemia	___Emphysema
___Vascular disease	___Leukemia	___Other
___Other	___Bleeding Disorder	
	___Other	

Patient Signature_____ **Date:**_____

Doctor Reviewed_____ **Date:**_____