NAPER GROVE VISION CARE

_____ **Name**
_____ **Account**

CONSTITUTIONAL ☐ **YES** ☐ **NO**
☐ Fever
☐ Weight Gain/Loss
☐ Other_____

CARDIOVASCULAR ☐ **YES** ☐ **NO**
☐ Heart Disease
☐ High Cholesterol
☐ High Blood Pressure
☐ Other_____

EAR, NOSE, MOUTH, And THROAT ☐ **YES** ☐ **NO**
☐ Sinus Congestion
☐ Cough
☐ Other_____

RESPIRATORY ☐ **YES** ☐ **NO**
☐ Asthma
☐ Chronic Bronchitis
☐ Emphysema
☐ Other_____

GASTROINTESTINAL ☐ **YES** ☐ **NO**
☐ Diarrhea
☐ Constipation
☐ Other_____

GENITOURINARY ☐ **YES** ☐ **NO**
☐ Genitals/Kidney/Bladder
☐ Other_____

BONES/JOINTS/MUSCLES ☐ **YES** ☐ **NO**
☐ Rheumatoid Arthritis
☐ Muscle Pain
☐ Other_____

PSYCHIATRIC ☐ **YES** ☐ **NO**
_____

DIABETIC ☐ **YES** ☐ **NO**
☐ Less than 6 Months
☐ 6 Months – 3 Years
☐ 3 Years +
Last Fasting Blood Sugar _____
HbA1C_____

HEIGHT ____Ft____in **Weight** _____lbs

PREGNANT or NURSING ☐ **YES** ☐ **NO**

SURGICAL HISTORY
List any major injuries, Illness, surgeries, and or hospitalizations.

_____
_____
_____
_____

Patient Ocular History

Glaucoma ☐ **YES** ☐ **NO**
Cataracts ☐ **YES** ☐ **NO**
Macular Degeneration ☐ **YES** ☐ **NO**
Eye Injury ☐ **YES** ☐ **NO**
Retinal Disease ☐ **YES** ☐ **NO**
Other Disease ☐ **YES** ☐ **NO**
Blindness ☐ **YES** ☐ **NO**
Strabismus ☐ **YES** ☐ **NO**
Amblyopia ☐ **YES** ☐ **NO**
Flashes/Floaters ☐ **YES** ☐ **NO**
Frequent Headaches ☐ **YES** ☐ **NO**

Other _____

Do you wear glasses? ☐ **YES** ☐ **NO**
☐ Full Time ☐ Part Time

☐ Distance ☐ Reading
☐ Computer

Do you wear contacts? ☐ **YES** ☐ **NO**
☐ Full Time ☐ Part Time

☐ Hard ☐ Soft

Brand: _____

Solution: _____

If NOT a contact lens wearer, are you interested in trying contact lenses at this time? ☐ **YES** ☐ **NO**

SOCIAL HISTORY
Do you use tobacco products? ☐ **YES** ☐ **NO**
Type/Amount/How long:

_____

Do you use illegal drugs? ☐ **YES** ☐ **NO**
Type/Amount/How Long:

_____

Do you drink alcohol? ☐ **YES** ☐ **NO**
Type/Amount/How Long:

_____

Occupation:

_____

Hobbies:

_____

_____ **Name**
_____ **Account**

Family History

			Mother	Father	Maternal Grandmother	Paternal Grandmother	Maternal Grandfather	Paternal Grandfather	Sister	Brother
Glaucoma	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Cataracts	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Eye Injury	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Retina Disease	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Other Eye Disease	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Strabismus	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Amblyopia	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Blindness/Vision Loss	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐
Other Family History	☐ **No**	☐ **Yes:**	☐	☐	☐	☐	☐	☐	☐	☐

Allergies/ Medications

Please list any medications you are currently taking (including oral contraceptives, eye drops, aspirin, over the counter medications and home remedies.)

Drug Name: **Reason:**

Please list any allergies (including drug, environmental, food, etc.)

The information contained herein is a part of your medical record and will be kept confidential.
No Information will be released without the consent
of the patient or the patient's guardian.