SOUTH VALLEY EYECARE CENTER

David A. Smith O.D.

Name ______________________________
Mailing Address ____________________________
City ___________ State ____ Zip Code __________
Phone Home/Cell ____________________________
Can we text you **Yes** **No**
Social Security Number ___________________
Employer or School ________________________
Occupation or Grade_______________________

MEDICAL HISTORY

Allergies	No	Yes	Arthritis	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Skin Disorder	No	Yes	Diabetes	No	Yes
Eye Disease	No	Yes	Heart Disease	No	Yes
Eye Injury	No	Yes	High Blood Pressure	No	Yes
Eye Surgery	No	Yes			
Lazy Eye	No	Yes	Kidney	No	Yes
Cataracts	No	Yes	Nerves	No	Yes
Glaucoma	No	Yes	Other ____________		
Pregnant	No	Yes	________________		

CURRENT MEDICATIONS (Rx and Over the Counter)

			Name of Medication
Antihistamines	No	Yes	______________
Diuretics (water pill)	No	Yes	______________
Blood Pressure Pills	No	Yes	______________
Oral Contraceptives	No	Yes	______________
Sleeping Tablets	No	Yes	______________
Eye Drops	No	Yes	______________

Other ______________________________________
____
Are you currently under the care of a physician?
No Yes
Name of physician ___________________________

FAMILY MEDICAL HISTORY

			Relationship
Blindness	No	Yes	______________
Cataracts	No	Yes	______________
Glaucoma	No	Yes	______________
Diabetes	No	Yes	______________
Macular Degen	No	Yes	______________

Other ______________________________________

Today's Date _______ Date of Last Exam ___________
Date of Birth __________ Age _____ Sex: M F
What is the major purpose of this visit? ____________
____
Any problems with your present contacts or glasses?
____
Spouse or Parent's Name ______________________
Spouse or Parent's Work Phone__________________

How will you settle your account today?
Credit/Debit Card ______ Cash ______ Check _______
Vision Insurance ____________________________
Health/Medical Insurance ______________________
Who is the responsible party?___________________

Do You... (Please circle)

..Work at a computer for long periods?	Yes	No
..Have more than one pair of glasses?	Yes	No
..Want information on thinner or lighter lenses?	Yes	No
..Always like to wear glasses?	Yes	No
..Feel uncomfortable in bright sunlight?	Yes	No
..Have prescription sunglasses?	Yes	No
..Have problems with glare or reflections, particularly when driving at night?	Yes	No

Have you ever worn or are you currently wearing contact lenses? Yes No
What kind? ___________ Solutions used ___________
Are you interested in contacts lenses? Yes No

Do you experience... (Please circle)

Burning	Sensitivity to light
Sudden vision loss	Itchiness
Soreness	Fainting or dizziness
Eye Strain	Flashes of light
Blurry distance vision	Headaches
Blurry near vision	Spots
Dryness	Redness
Trouble seeing at night	Gritty feeling in eyes
Double vision	Glare or reflections
Watery eyes/ tearing	Uncomfortable glasses
Objects floating in vision	Uncomfortable contacts
Trouble reading/working up close	

Other ____________________________________

Who can we thank for referring you to our office?

Who?
Friend/Relative/Previous patient? ______________
Other Health Care Practitioner? ______________
Other______________________________________
____