DESOTO EYE CARE

Patient Name:_____

PLEASE CIRCLE YOUR RESPONSE ON EACH LINE

1= "A Little" 2= "Some" 3= "A lot"

(Leave line blank if it does not apply)

Have you been bothered by:				Comments
1	2	3	Overall decline in vision	
1	2	3	Blurry vision	
1	2	3	Glare or poor night vision	
1	2	3	Sensitivity to light	
1	2	3	Seeing rings or halos around lights	
1	2	3	Seeing double	

Have you noticed a decrease in you vision when you:				Comments
1	2	3	Drive during daylight hours	
1	2	3	Driving during evening hours	
1	2	3	See traffic signs or signals	
1	2	3	Read newspapers or telephone book	
1	2	3	Read labels, price tags or medicine bottles	
1	2	3	Use a computer	
1	2	3	Do fine handwork or hobbies	
1	2	3	Look at colors	
1	2	3	Sew, cook or work around the house	
1	2	3	Play cards	
1	2	3	Watch TV	
1	2	3	Look at steps or curbs	
1	2	3	Work at your job	
1	2	3	Try to recognize people	
1	2	3	Look out of only one eye	
1	2	3	Other	

_____ _____

Patient's Signature Date

Patient History Form

Patient Name _____ Date _____

How did you hear about us? ❒ Walk-in ❒Physician ❒Insurance ❒ Yellow Pages ❒Friend

REVIEW OF SYSTEMS
Do you currently have any of the following problems?

1. GENERAL SYMPTOMS (Fever, weight loss, other)	☐yes ☐no	
2. EYES (Glaucoma, cataract, lazy eye, retina problems Other - please specify)	☐yes ☐no	
3. EARS/NOSE/MOUTH/THROAT (Hearing loss, sinus problems, sore throat)	☐yes ☐no	
4. CARDIOVASCULAR (Heart problems, chest pain, irregular heart beat)	☐yes ☐no	
5. RESPIRATORY (Asthma, shortness of breath, wheezing, coughing)	☐yes ☐no	
6. GASTROINTESTINAL (belly pain) (Heartburn, diarrhea, vomiting)	☐yes ☐no	
7. GENITOURINARY (Urinary problems, blood in urine)	☐yes ☐no	
8. INTEGUMENTARY (Skin rashes, excessive dryness)	☐yes ☐no	
9. MUSCULOSKELETAL (Muscle aches, joint pain, swollen joints)	☐yes ☐no	
10. NEUROLOGICAL (Numbness, weakness, headaches, paralysis)	☐yes ☐no	
11. HEMATOLOGIC/LYMPHATIC (Blood disorders, leukemia, low blood count, anemia)	☐yes ☐no	
12. ALLERGIC/IMMUNOLOGIC (Hay fever, allergies)	☐yes ☐no	
13. ENDOCRINE (Thyroid problems)	☐yes ☐no	
14. PSYCHIATRIC (Depression, anxiety)	☐yes ☐no	

Family and Social History: Do any medical or eye diseases run in your family. If YES, Please note relationship to patient.

❒ Glaucoma _____

❒ Diabetes _____

❒ High blood pressure _____

❒ Macular degeneration _____

❒ Other _____

Do you smoke? If YES, how much? _____

Drink alcohol? If YES, how much? _____

Marital Status _____

Comments: _____

Physician Signature _____ *Date* _____