Welcome To Our Office

Office: **Ashburn Chantilly (please circle one)** **Date of appointment: _____**

Patient Name: (First) _____ (M.I.) _____ (Last) _____ S.S.# _____

Address: _____ City, State, Zip: _____

Telephone: (H) _____ (W) _____ Cell or Beeper _____ E-mail: _____

D.O.B. _____/_____/_____ Age: _____ Sex: o Male o Female

Occupation: _____ Employer: _____

How Did You Hear About Our Office? (Please be specific): _____

Date of Last Eye Exam _____ Dilated o No o Yes Last Eye Doctor: _____
approximate if unsure

Vision Insurance Plan: _____ Primary Care Physician: _____

Person responsible for account: _____ Patient Signature: _____
Parent or Guardian if under 18 years of age

REASON FOR TODAY'S VISIT: _____

MEDICAL HISTORY:

Do you have any allergies to medications? o No o Yes If yes, please list: _____

List all medications and conditions for which you are taking these meds: _____

_____

_____

OCULAR HISTORY:

Have you ever had an eye injury, eye operation, or serious eye infection? o No o Yes If yes, please explain _____

_____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, cataracts, retinal disease or detachment? _____

Are you pregnant and/or nursing? o No o Yes If yes, what is/was your delivery date? _____

Have you ever worn glasses? o No o Yes If yes, how old is your present pair of lenses? _____

Have you ever worn contact lenses? o No o Yes If yes, how old is your present pair? _____

Type of contact lenses: o Rigid o Soft o Extended Wear o Disposable o Other Are they comfortable? o No o Yes

If disposable, how often do you dispose of them? o 1-2 Weeks o 1 Month o 2 Month o 3 Month o Other _____

FAMILY HISTORY:

Please note any family history (parents, grandparents, etc.) for the following conditions:

DISEASE/CONDITION	NO	YES	RELATIONSHIP TO YOU
Cataract	o	o	_____
Glaucoma	o	o	_____
Macular Degeneration	o	o	_____
Retinal Detachment	o	o	_____
Diabetes	o	o	_____
Cancer	o	o	_____
Heart Disease	o	o	_____
High Blood Pressure	o	o	_____

Other o o _____

SOCIAL HISTORY: *This information is kept strictly confidential. Please answer all the questions that apply:*

Do you drive? o No o Yes Do you have visual difficulty when driving? o No o Yes If yes, please describe problem:

_____

Do you use tobacco products? o No o Yes Do you drink alcohol? o No o Yes Do you use illegal drugs? o No o Yes

Have you ever been exposed to or infected with: o Gonorrhea o Hepatitis o HIV o Syphilis

REVIEW OF SYSTEMS:

Do you currently have any problems in the following area?

SYSTEM	NO	YES
CONSTITUTIONAL		
Fever, Weight Loss/Gain	o	o
INTEGUMENTARY (Skin)	o	o
NEUROLOGICAL		
Headaches	o	o
Migraines	o	o
Seizures	o	o
EYES		
Loss of Vision	o	o
Blurred Vision	o	o
Distorted Vision/Halos	o	o
Loss of Side Vision	o	o
Double Vision	o	o
Dryness	o	o
Mucous Discharge	o	o
Redness	o	o
Sandy or Gritty Feeling	o	o
Itching	o	o
Burning	o	o
Foreign Body Sensation	o	o
Excess Tearing/Watering	o	o
Glare/Light Sensitivity	o	o
Eye Pain or Soreness	o	o
Chronic Infection of Eye or Lid	o	o
Sties or Chalazion	o	o
Flashes/Floaters in Vision	o	o
Tired Eyes	o	o
ENDOCRINE		
Thyroid/Other Glands	o	o

SYSTEM	NO	YES
EAR, NOSE, MOUTH, THROAT		
Allergies/Hay Fever	o	o
Sinus Congestion	o	o
Runny Nose	o	o
Post-Nasal Drip	o	o
Chronic Cough	o	o
Dry Throat/Mouth	o	o
RESPIRATORY		
Asthma	o	o
Chronic Bronchitis	o	o
Emphysema	o	o
VASCULAR/CARDIOVASCULAR		
Diabetes	o	o
Heart Pain	o	o
High Blood Pressure	o	o
Vascular Disease	o	o
GASTOINTESTINAL		
Diarrhea	o	o
Constipation	o	o
GENITOURINARY		
Genitals/Kidneys/Bladder	o	o
BONES/JOINTS/MUSCLES		
Rheumatoid Arthritis	o	o
Muscle Pain	o	o
Joint Pain	o	o
LYMPHATIC		
Anemia	o	o
Bleeding Problems	o	o
ALLERGIC/IMMUNOLOGIC	o	o
PSYCHIATRIC	o	o

If you answered YES to any of the above, or have a condition not listed, please explain and list medications:

_____

_____

_____

_____

_____

_____ _____

Doctor's Signature **Date**