

Date: _____

I CARE VISION CENTERS

Doctor: _____

Patient Name: _____

Patient Birthdate: _____

Purpose of appointment: Routine Exam/Glasses/Contacts/Eye Injury/Eye Infection/Laser Vision Correction

Other: _____

List your occupation, hobbies, or other task affecting your vision: _____

Please circle **yes** or **no** for each of the following as each applies to you:

- | | | |
|-----------------------------|--------------------------------------|--------------------------------|
| Y/N Diabetes | Y/N Collagen Vascular Disease | Y/N Retinal Disease/Detachment |
| Y/N Asthma | Y/N Arthritis | Y/N Macular Degeneration |
| Y/N Heart/Vascular Disease | Y/N Fainting/Dizziness | Y/N Cataracts |
| Y/N Kidney/Liver Disease | Y/N Allergies/Hayfever | Y/N Glaucoma |
| Y/N High/Low Blood Pressure | Y/N Hearing Problems | Y/N Dry/Itching Eyes |
| Y/N Thyroid Disease | Y/N Eye/Head Injury | Y/N Eye Surgery |
| Y/N Multiple Sclerosis | Y/N Sudden Vision Loss | Y/N Eye Turn/Lazy Eye |
| Y/N Cancer/Tumors | Y/N Double Vision | Y/N Pregnant/Nursing (women) |
| Y/N Hepatitis A/B/C | Y/N Color Blindness | Y/N Use Tobacco/Alcohol |
| Y/N HIV/AIDS | Y/N Flashes/Floaters/Spots in Vision | Y/N Use Other Substances |

Family History:

- Y/N High Blood Pressure
 - Y/N Diabetes
 - Y/N Migraines
 - Y/N Glaucoma
 - Y/N Cataracts
 - Y/N Macular Degeneration
 - Y/N Retinal Detachment
- Other: _____

List all medications:

(include oral contraception, hormone replacement, aspirin, over the counter, herbal and vitamins)

List allergies to medications:

Do you have headaches? Y/N

If yes, please specify:

Location: _____

Frequency: _____

Duration: _____

Time of onset: _____

Cause: _____

Type of pain: dull/sharp/throbbing

Constant/intermittent

Do you wear contact lenses? Y/N

Type: Soft / Rigid / Toric

Daily Wear/Extended Wear/Disposable

Solution: _____

Average hours of wear per day: _____

Do you sleep in your lenses? Y/N

of nights per week: _____

Other information: _____

Name of Physician: _____

Date of Last Physical: _____

Name of Last Eye Doctor: _____

Date of Last Eye Exam: _____