Springboro Vision Center

Name: _____ **Date:** _____ **Date of Birth:** _____

Occupation: _____ **Email:** _____

Do you wear glasses? Y N Fulltime, distance, or reading only? _____ How long have you had them? _____

Do you wear contact lenses? Y N Soft or Gas Permeable (hard)? _____ Brand: _____
How often do you sleep in them? _____ Hours per day you wear them? _____ Power: R_____ L_____ BC_____
How often do you replace them? _____

Are you interested in contact lenses? Y N

Have you ever been diagnosed with any of the following conditions?

Y N Cataracts
Y N Macular Degeneration
Y N Glaucoma
Y N Diabetic Retinopathy
Y N Dry Eye
Y N Eye Infection/Inflammation/Allergy
Y N Floating Spots/Flashing Lights
Y N Iritis or Uveitis
Y N Retina Defects/Degenerations

Are you having any of the following eye concerns?

Y N Redness
Y N Burning
Y N Itching
Y N Tearing
Y N Discharge
Other: _____

Are you having any of the following vision concerns?

Y N Blurred Vision
Y N Eyestrain
Y N Eye Pain
Y N Severe Light Sensitivity
Y N Headaches
Y N Poor Night Vision
Y N Bothersome Night Glare
Other: _____
Y N Glare/Halos
Y N Double Vision
Y N Total Loss of Vision

Do you experience any problems in the following areas?
(Please include all conditions, even those which are under control with medication.)

Constitution:
Y N Developmental Disability
Y N Cancer (If yes, type: _____)
Y N Fatigue Syndrome

Ear/Nose/Throat:
Y N Hearing Loss
Y N Sinusitis
Y N Dry Mouth

Neurological:
Y N Multiple Sclerosis
Y N Epilepsy
Y N Cerebral Palsy
Y N Tumor
Y N Migraine
Y N Autism Spectrum Disorder

Respiratory:
Y N Cigarette Smoker
Y N Asthma
Y N Bronchitis
Y N Emphysema
Y N Chronic Obstruction
Y N Sleep Apnea

Gastrointestinal:
Y N Colitis
Y N Ulcer
Y N Acid Reflux
Y N Celiac Disease
Y N Crohn's

Integumentary (Skin):
Y N Eczema
Y N Rosacea
Y N Psoriasis
Y N Herpes Simplex/Cold Sores
Y N Herpes Zoster/Shingles

Endocrine
Y N Type 2 Diabetes HbA1C _____
Blood Sugar Range _____ to _____
Y N Type 1 Diabetes _____ HbA1C _____
Blood Sugar Range _____ to _____
Y N Thyroid Dysfunction
Y N Hormonal Dysfunction

Are you sensitive to latex? Y N
Are You Pregnant? Y N
Are you nursing? Y N
Do you use tobacco? Y N What type? (cigarette, cigar, etc.) _____ How often/much? _____
Do you drink alcohol? Y N How often/much? _____

Do you have an immediate family history of the following? (Include grandparents)
Please list those affected in space provided. (Example, if your mother has had cancer, circle "Y" then writes "mother" on line provided.)

Cancer_____ Y N
Type 1 Diabetes _____ Y N
Type 2 Diabetes _____ Y N
Hypertension _____ Y N
Cataract _____ Y N
Macular Degeneration _____ Y N
Glaucoma _____ Y N
Hyperthyroidism _____ Y N

Primary care Physician (First & Last Name): _____

Date of Last Physical Exam: _____

List all medications you take (Including Rx, Over-the-counter, and Eye drops):

List all allergies (Including Drug, Food, and Environmental):

Psychiatric:
Y N Depression
Y N Attention Deficit
Y N Anxiety Disorder
Y N Bipolar Disorder

Cardiovascular:
Y N Hypertension
Y N Stroke/CVA
Y N Heart Disease
Y N Vascular Disease
Y N Congestive Heart Failure

Genitourinary:
Y N Kidney Disease
Y N Prostate Disease/Cancer
Y N Benign Prostate Hypertrophy
Y N Pregnant
Y N Nursing
Y N Herpes
Y N Chlamydia

Musculoskeletal:
Y N Osteoarthritis
Y N Arthritis
Y N Fibromyalgia
Y N Muscular Dystrophy
Y N Ankylosing Spondylitis
Y N Osteoporosis
Y N Gout

Hematologic/Lymphatic
Y N Anemia
Y N Large-Volume Blood Loss
Y N Ulcer
Y N High Cholesterol

Allergy/Immunity
Y N Drug Allergies
Y N Environmental Allergies
Y N Rheumatoid Arthritis
Y N Lupus
Y N Sjogren's Syndrome

Other conditions not listed include: