



WELCOME TO NORTHERN VIRGINIA DOCTORS OF OPTOMETRY

TODAY'S DATE: _____

PATIENT NAME: _____ DOB: _____

PERSONAL EYE INFORMATION

We would like to thank the person who referred you to our office: How did you hear about us? (friend, co-worker, family, yellow pages, insurance, etc.) _____

Date of Last Eye Examination: _____ Doctor's Name: _____

So we may better serve your vision needs, please complete the questions below regarding your visit to our office:

- Do you work on a computer? If so, how many hours a day? _____

Your reason(s) for visiting our office today: (please check all applicable items)

<input type="checkbox"/> General check up	<input type="checkbox"/> Headaches	<input type="checkbox"/> Want contact lenses
<input type="checkbox"/> Laser vision consultation	<input type="checkbox"/> Light sensitivity	<input type="checkbox"/> Standard soft
<input type="checkbox"/> Lost or broken glasses	<input type="checkbox"/> Eyes water	<input type="checkbox"/> Disposable
<input type="checkbox"/> Want new eyeglasses	<input type="checkbox"/> Eyes itch	<input type="checkbox"/> Tinted/ colored
<input type="checkbox"/> Blurred distance vision	<input type="checkbox"/> Eyes feel dry	<input type="checkbox"/> Bifocal/ Multifocal
<input type="checkbox"/> Blurred intermediate vision	<input type="checkbox"/> Pain in eyes	<input type="checkbox"/> Gas permeable
<input type="checkbox"/> Blurred near vision	<input type="checkbox"/> Flashes of lights	<input type="checkbox"/> Other
<input type="checkbox"/> Night vision problems	<input type="checkbox"/> Floating spots in vision	
<input type="checkbox"/> Double vision	<input type="checkbox"/> Eyes feel tired	

Contact Lens Questionnaire:

- Are you wearing contact lenses today? ___ Yes ___ No
- If yes, what type? ___ Soft ___ Rigid/ Gas Permeable
- What type of solution do you use to clean and disinfect: _____
- Have you worn contact lenses in the past? If so, please tell us why you quit _____

Please mark those activities in which you participate:

<input type="checkbox"/> Tennis	<input type="checkbox"/> Basketball	<input type="checkbox"/> Skiing	<input type="checkbox"/> Football	<input type="checkbox"/> Dancing	<input type="checkbox"/> Woodworking
<input type="checkbox"/> Soccer	<input type="checkbox"/> Swimming	<input type="checkbox"/> Hunting	<input type="checkbox"/> Fishing	<input type="checkbox"/> Golf	<input type="checkbox"/> Rollerblading
<input type="checkbox"/> Biking	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Walking	<input type="checkbox"/> Scuba Diving	<input type="checkbox"/> Reading	<input type="checkbox"/> Baseball
<input type="checkbox"/> Gardening	<input type="checkbox"/> Crafts	<input type="checkbox"/> Jogging	<input type="checkbox"/> Sewing	<input type="checkbox"/> Aerobics	<input type="checkbox"/> Musical Instrument

SOCIAL HISTORY

- Do you drive? ___ YES ___ NO
- If yes, do you have visual difficulty when driving? ___ NO ___ YES
(describe) _____
- Do you use tobacco products? ___ NO ___ YES
- If yes, type/amount/how long: _____
- Do you drink alcohol? ___ NO ___ YES
- If yes, type/amount/how long: _____
- Do you use illegal drugs? ___ NO ___ YES
- If yes, type/amount/how long: _____
- Have you been exposed to or infected with the following: ___ Gonorrhea ___ Syphilis ___ HIV ___ Hepatitis

PLEASE TURN THIS FORM OVER AND COMPLETE OTHER SIDE

Patient name: _____ DOB: _____

FAMILY HISTORY	NO	YES	UNSURE	RELATIONSHIP TO YOU		
Please check any family history (parents, grandparents, siblings, and/ or children, living or deceased) for the following medical conditions: Date reviewed & Doctor's initials						
BLINDNESS						
CATARACTS						
CROSSED EYES						
GLAUCOMA						
MACULAR DEGENERATION						
RETINAL DETACHMENT/ DISEASE						
ARTHRITIS						
CANCER						
DIABETES						
HEART DISEASE						
HIGH BLOOD PRESSURE						
HIGH CHOLESTEROL						
KIDNEY DISEASE						
LUPUS						
THYROID DISEASE						
LUNG DISEASE						
MEDICAL HISTORY				Date of Last Medical Exam: _____		
Name of Medical Doctor: _____				Doctor's Phone #: _____		
List any MEDICATIONS you take (including oral contraceptives, aspirin, over the counter medications and home remedies): _____						

Do you have any ALLERGIES to medications? ___ NO ___ YES please list _____						
List all major surgeries, injuries and/ or hospitalizations you have had: _____						

MEDICAL HISTORY	NO	YES	UNSURE	EXPLAIN/ MEDICATIONS		
Do you currently, or have you ever had any problems in the following areas: (If YES, please explain and list medications.)						
INTEGUMENTARY/ SKIN						
NEUROLOGIC						
Headaches, Migraines, Seizures						
EARS, NOSE, MOUTH, THROAT						
Allergies, Hay fever						
Sinus Congestion						
Runny nose, Post-nasal drip						
RESPIRATORY						
Asthma						
Chronic Bronchitis, Emphysema						
VASCULAR						
Cholesterol						
Diabetes						
Heart, Vascular disease						
High blood pressure						
GASTROINTESTINAL						
Diarrhea/ constipation						
BONES/ JOINTS/ MUSCLES						
Rheumatoid Arthritis, Joint pain						
LYMPHATIC						
Anemia/ Bleeding problems						
ENDOCRINE						
Thyroid/ other glands						
PSYCHIATRIC						
Depression/ Anxiety/ other						

Doctor's Signature: _____

Review Date: _____