Your Name___________________

Foresight Optometry

Please tell us reasons for your visit today (Please select all that apply):

☐Need updated contacts	☐Recommended by School	☐Diabetic Annual Exam
☐Need updated glasses	☐Recommended by Doctor	☐My parents made me come
☐Yearly eye exam	☐Other reason: ____	

Do you have any of the following symptoms? ☐ **NONE**

Blurred distance vision	☐Yes	Headache	☐Yes	Dryness	☐Yes
Blurred near vision	☐Yes	Poor night vision	☐Yes	Redness	☐Yes
Eyestrain	☐Yes	Night glare	☐Yes	Burning	☐Yes
Eye pain	☐Yes	Double vision	☐Yes	Itching	☐Yes
Light sensitivity	☐Yes	Fluctuating vision	☐Yes	Tearing	☐Yes
Floaters or spots	☐Yes	Loss of vision	☐Yes	Discharge	☐Yes

Other: ____________________________________

Have you had any EYE conditions?	☐ **NONE**	**Have any HEALTH conditions?** (**Circle** those that apply)	☐ **NONE**
Cataracts	☐Yes	Constitution (Developmental Disability, Fatigue Syndrome,	☐Yes
Macular Degeneration	☐Yes	Cancer Type:_______________)	☐Yes
Glaucoma	☐Yes	Ear, Nose, Throat (Hearing loss, Sinusitis, Dry mouth…)	☐Yes
Diabetic Retinopathy	☐Yes	Neurological (Epilepsy, CP, MS, Stroke, Migraines…)	☐Yes
Dry Eye	☐Yes	Psychological (Depression, Bipolar, Anxiety…)	☐Yes
Strabismus (eye turn)	☐Yes	Cardiovascular (Blood pressure, Stroke, CHF…)	☐Yes
Amblyopia (lazy eye)	☐Yes	Respiratory (Asthma, COPD, Sleep Apnea, Emphysema…)	☐Yes
Iritis or Uveitis	☐Yes	Gastrointestinal (Crohn's, Colitis, Ulcers, Celiac…)	☐Yes
Retinal Holes or Tears	☐Yes	Genitourinary (Kidney, Prostate, STDs, Herpes…)	☐Yes
Retinal Detachment	☐Yes	Musculoskeletal (Gout, Arthritis, Fibromyalgia…)	☐Yes
Keratoconus	☐Yes	Integ/Skin (Eczema, Rosacea, Psoriasis, Herpes…)	☐Yes
Eye Injury or Trauma	☐Yes	Endocrine (Diabetes Type I or II, Thyroid, Hormones…)	☐Yes
Surgery:	☐Yes	Blood Disease (Cholesterol, Anemia, Sickle…)	☐Yes
Other:		Autoimmune (Rheumatoid Arthritis, Lupus, Sjogrens…)	☐Yes
		Other:____________________________________	

Do you have any allergies? ☐ **No** ☐ **Yes** **Please list:** ________________________________

Do you drink alcohol? ☐ **No** ☐ **Yes** **How much/often?**__________

Do you use tobacco? ☐ **Never** ☐ **Former Smoker** ☐ **Current Smoker: How much/often?**_________________

Do you use recreational drugs? ☐ **No** ☐ **Yes** **Please list:** ________________________________

Are you pregnant or nursing? ☐ **No** ☐ **Yes**

Are you interested in LASIK? ☐ **No** ☐ **Yes**

************PLEASE TURN OVER************

Family Health Conditions:	Relationship:	**Family Eye Conditions:**	Relationship:
☐ **NONE**		☐ **NONE**	
Cancer ☐Yes		Cataract ☐Yes	
Diabetes Type 1 ☐Yes		Macular degeneration ☐Yes	
Diabetes Type 2 ☐Yes		Glaucoma ☐Yes	
Hypertension ☐Yes		Retinal detachment ☐Yes	
Hyperthyroid ☐Yes		Amblyopia (lazy eye) ☐Yes	
Hypothyroid ☐Yes			

Medication list

Drug name	Dosing	Drug name	Dosing

Primary care doctor's name: ______________________________________
Primary care doctor's office name: ________________________________
Primary care doctor's phone number: ______________________________

Hobbies:
____