Sterling Optical

General Information

Date:

Last Name_____ First Name: _____M _____DOB: ____/____/____

Sex:☐Male ☐Female SSN: _____ / _____ / _____ Marital Status:☐Married ☐Single ☐ Divorced

Address: _____ City: _____ State: _____ Zip: _____

Home Ph: _____ Work Ph: _____ Cell Ph: _____

Employer/School:_____ Occupation/School Grade:_____

E-mail Address: _____ Sports/Hobbies: _____

Emergency Contact: _____ Relation: _____ Phone #: _____

REASON FOR VISIT: _____

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:_____

Date of Last Eye Exam:_____/_____/_____ Clinic/Eye Doctor's Name:_____

Do you wear glasses?☐No☐Yes **If yes:** ☐Driving only ☐Reading only ☐Work only ☐Sometimes ☐All the time

How old are your present glasses: _____ Do you wear prescription Sun Wear:☐Yes ☐No

Do you wear contacts?☐Yes☐No Type:__ _____ Solution Used: _____

Wearing Schedule:☐ **Daily** ☐ **Overnight** Replacement schedule:☐**Daily**☐**2 week** ☐**Monthly** ☐ **Yearly**

Have you ever had eye injuries? ☐Yes ☐No Which Eye?_____

Have you ever had eye surgeries?☐Yes☐No Why?_____

Have you used eye medication?☐Yes☐No Why?_____

Are you currently pregnant or nursing? ☐Yes ☐No ☐N/A

Have you ever been diagnosed with?

Cataracts: ☐Yes ☐No When were you diagnosed?_____

Glaucoma: ☐Yes ☐No When were you diagnosed?_____

Macular Degeneration: ☐Yes ☐ No When were you diagnosed?_____

What are your visual symptoms: Please check any that apply:

- ☐ Blurred Vision/Distance
- ☐ Blurred Vision/Near
- ☐ Double Vision
- ☐ Eye Strain
- ☐ Eye Infections
- ☐ Eye Pain/Soreness
- ☐ Tired eyes
- ☐ Burning Eyes
- ☐ Itchy Eyes
- ☐ Dry Eyes
- ☐ Red Eyes
- ☐ Watery Eyes
- ☐ Wandering eye
- ☐ Mucus Discharge
- ☐ Floaters or Spots
- ☐ See Flashes
- ☐ See Halos
- ☐ Poor Night Vision
- ☐ Headaches
- ☐ Migraine Headaches
- ☐ Loss of Vision
- ☐ Crossed Eyes
- ☐ Light Sensitive
- ☐ Sandy/Gritty Feeling
- ☐ Poor Color Vision
- ☐ Droopy Lid

Please complete next page

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: ☐ None ☐ Hypertension ☐ Stroke ☐ Heart Disease ☐ Vascular Disease ☐ High Cholesterol ☐ Other:	**Endocrine:** ☐ None ☐ Non-Insulin Dependent Diabetes ☐ Insulin Dependent Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other:	**Respiratory:** ☐ None ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other:
Constitutional: ☐ None ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other:	**Ocular** ☐ None ☐ Glaucoma ☐ Macular Degeneration ☐ Detached Retina ☐ Other:	**Psychiatric:** ☐ None ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other:
Neurological: ☐ None ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other:	**Musculoskeletal:** ☐ None ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other:	**Immunologic:** ☐ None ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other:
Hematological: ☐ None ☐ Anemia ☐ Leukemia ☐ Other:	**Gastrointestinal** ☐ None ☐ Crohn's ☐ Colitis ☐ Other:	**Ear/Nose/Throat:** ☐ None ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other:
Dermatologic: ☐ None ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other:	**Allergies** (please list) ☐ None Drug: Environmental:	**Alcohol Use:** ☐ Yes ☐ No Amount: **Tobacco Use:** ☐ Yes ☐ No Amount:

Please list physical reaction's to above allergies:

_____

Please list any medications and/or drugs that you are taking (including herbal) :

1	**For**	**2**	**For**
3	**For**	**4**	**For**
5	**For**	**6**	**For**
7	**For**	**8**	**For**
9	**For**	**10**	**For**

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION

Retinal Detachment: ☐ Yes ☐ No		Blindness: ☐ Yes ☐ No	
High Blood Pressure: ☐ Yes ☐ No		Cataracts: ☐ Yes ☐ No	
Diabetes: ☐ Yes ☐ No		Glaucoma: ☐ Yes ☐ No	
Cancer: ☐ Yes ☐ No		Crossed Eyes: ☐ Yes ☐ No	
Heart Disease: ☐ Yes ☐ No		Macular Degeneration: ☐ Yes ☐ No	
Thyroid Disease: ☐ Yes ☐ No		Lupus ☐ Yes ☐ No	

Reviewed by:

Dr _____ Date _____

Thank you for completing the Patient History form! You may submit this document one of two ways:

First way:

Click the grey **submit** button below. A dialogue box will pop up prompting you to choose from your default email or another internet-based email. The Sterling Optical email address will automatically paste into your address bar with this document attached. Click the send button on your computer to submit your form.

Submit

Second way:

Save this document to this computer. Open up your email and compose a message to eyecare@sterlingopticalec.com and attach this document. Send the message.