# Blue Mountain Optometry

## Welcome to our Office

Date: _____

Name: _____Date of birth: _____ Age: ____ Male __ Female__

Parent's name (If patient is a child):_____

Address: _____ City: _____Zip:_____

Email: _____ Home phone: _____

Cell Phone: _____ Work phone: _____ Pref.: Home/Work/Cell

Name/office of last eye exam: _____ Date of last exam: _____

Name/office of primary care physician: _____Date of last exam: _____

Employer/School: _____Occupation: _____

Who may we thank for referring you to our office: _____

Vision Insurance: _____ ID: _____ Medical Insurance: _____ ID: _____

Flex spending: Yes/No Emergency contact/Phone number: _____

**What is the reason for today's visit: Please check one or more:**

| | | |
|---|---|---|
| ( ) Distance blurred vision | ( ) Near blurred vision | ( ) Double vision |
| ( ) Sudden loss of vision | ( ) Eye itching or allergies | ( ) Eye watering or tearing |
| ( ) Floating spots in vision | ( ) Seeing flashes of light | ( ) Red eyes |
| ( ) Dry/burning eyes | ( ) Eye pain or soreness | ( ) Frequent eyestrain |
| ( ) Frequent headaches | ( ) Unusual light sensitivity | ( ) Foreign matter in eyes |

Other_____

**Review of Systems: (Please circle all that apply)**

- **<u>Constitution:</u> Developmental Disabilities, Cancer, Fatigue Syndrome, Other:**
- **<u>Ear/Nose/Throat:</u>** Hearing Loss, Sinus Problems, Dry Mouth, Laryngitis. Other:
- **<u>Neurological:</u>** Multiple Sclerosis, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraine, Autism Spectrum Disorder, Other:
- **<u>Psychiatric:</u>** Depression, Attention Deficit, Anxiety Disorder, Bipolar Disorder, Other:
- **<u>Cardiovascular:</u> High Blood Pressure**, Stroke, Heart Disease, Vascular Disease, Congestive Heart Failure, Other:
- **<u>Respiratory:</u>** Cigarette Smoker, Asthma, Bronchitis, Emphysema, Chronic Obstruction, Sleep Apena, Other:

- **Gastro Intestinal:** Crohn's, Colitis, Ulcer, Acid Reflux, Celiac Disease, Other:

- **Genito-Urinary:** Kidney Disease, Prostate Cancer, Herpes, Chlamydia, Benign Prostate Hypertrophy, **Pregnant, Nursing**; Other:

- **Muscular/Skeletal:** Arthritis, Osteoarthritis, Fibromyalgia, Muscular Dystrophy, Ankylosing Spondylitis, Osteoporosis, Gout, Other:

- **Skin:** Eczema, Rosacea, Psoriasis, Herpes Simplex (Cold Sores), Herpes Zoster (Shingles), Other:

- **Endocrinology: Type 2 Diabetes, Type 1 Diabetes, Thyroid dysfunction**, Hormonal dysfunction, Other:

- **Hemotologic/ Lymphatic**: Anemia, Large-volume blood loss, Ulcer, **High Cholesterol**, Other:

- **Allergy/Immunologic:** Drug Allergies, Environmental Allergies, Rheumatoid Arthritis, Lupus, Sjogren's Syndrome, Other:

Please list all medications, vitamins, or supplements: _____
_____
_____

Are you allergic to any medications? Yes/No Please list: _____
_____

Have you had any eye disease, eye injury, or eye surgery? If yes, please explain:
_____

Hobbies: _____ Do you work with a computer? Y/N ____ Hours/day

Do you wear contact lenses? Y/N If yes, which brand/type? _____

What brand of contact lens cleaner do you use? _____

Drinking Yes/No Amt: _____; Tobacco use? Yes/No _____pack(s) per _____;

**Family Medical History:** Do any members of your immediate family have a history of the following? Please indicate their relation to YOU in the space provided. (father, mother, brother, son, or daughter)

( ) Diabetes type 2_____ ( ) Cancer _____ ( ) Hypertension_____
( ) Diabetes type 1_____ ( ) Thyroid _____ ( ) Cataracts _____
( ) Color deficiency _____ ( ) Lazy eye _____ ( ) Glaucoma _____
( ) Macular degeneration_____ ( ) Retinal detachment _____ Other: _____

**Signature:** _____ **Date:** _____