WALLINGFORD EYE CARE – OFFICE OF DR. SUSAN ROH

Patient Name:_____ Date:_____

DO YOU CURRENTLY:	ARE YOU INTERESTED IN:
☐ WEAR GLASSES AGE OF YOUR CURRENT GLASSES:_____	☐ CONTACT LENSES FOR EVERY DAY USE
☐ USE CONTACT LENSES BRAND OF CONTACT LENSES:_____	☐ CONTACT LENSES FOR SPORTS
	☐ CONTACTS FOR SOCIAL ACTIVITIES

YOUR VISUAL FUNCTION – Please check all that apply

☐ WORK ON COMPUTERS UNDER FLUORESCENT LIGHTING	☐ CONTACT LENSES GET DRY AT LEAST ONCE A DAY
☐ SPEND TIME OUTDOORS	☐ CONTACT LENSES ARE NOT AS CLEAR AS YOU WOULD LIKE
☐ EYES ARE SENSITIVE TO SUNLIGHT	☐ HAVE PROBLEMS WITH GLARE OR REFLECTION
☐ WOULD YOU LIKE INFORMATION ON THINNER/LIGHTER LENSES	☐ DO YOU SOMETIMES EXPERIENCE DRY EYES

DO YOU EXPERIENCE ANY OF THE FOLLOWING

☐ BLURRED VISION	☐ DRYNESS	☐ GLARE SENSITIVITY	☐ TIRED EYES
☐ BURNING	☐ EXCESSIVE TEARING	☐ GRITTY / SANDY FEELING	☐ ITCHING
☐ DISTORTED VISION	☐ EYE PAIN / SORENESS	☐ SUDDEN LOSS OF VISION	☐ LOSS OF SIDE VISION
☐ FLOATERS IN VISION	☐ FLASHES OF LIGHT	☐ EYE / EYELID INFECTION	☐ OTHER
☐ DROOPING EYELID	☐ DOUBLE VISION		

HAVE YOU HAD

☐ CATARACT SURGERY ☐ EYE MUSCLE SURGERY ☐ RETINAL SURGERY ☐ LASIK / PRK SURGERY ☐ TRAUMATIC EYE INJURY

EYE HISTORY Do you or any of your blood relatives have

Previous Eye Doctor _____

Last Eye Exam _____

F = father **M** = mother **S** = sibling **GP** = grandparent(s)

	YOU	FAMILY MEMBER
Amblyopia / lazy eye	☐	F M S GP
Blindness	☐	F M S GP
Cataracts	☐	F M S GP
Color Blindness	☐	F M S GP
Crossed / Turned eyes	☐	F M S GP
Diabetic Retinopathy	☐	F M S GP
Glaucoma	☐	F M S GP
Herpes Eye Disease	☐	F M S GP
Keratoconus	☐	F M S GP
Macular Degeneration	☐	F M S GP
Retinal Detachment	☐	F M S GP
Other Vision Disorders	☐	F M S GP

SOCIAL HISTORY

Do You Smoke NO YES _____ PACK(S) PER DAY

Alcohol Use NO YES _____ DRINK(S) PER WEEK

FEMALES: ARE YOU

☐ PREGNANT _____MONTHS

☐ NURSING

LIST ALLERGIES, INCLUDING DRUG ALLERGIES

LIST ALL CURRENT MEDICATIONS: RX & OTC

MEDICAL HISTORY Do you or any of your blood relatives have

Primary Care Doctor _____

Last Physical Exam _____

F = father **M** = mother **S** = sibling **GP** = grandparent(s)

	YOU	FAMILY MEMBER
Allergies	☐	F M S GP
Arthritis	☐	F M S GP
Blood disease (anemia, sickle)	☐	F M S GP
Breathing problems	☐	F M S GP
Cancer	☐	F M S GP
Cardiovascular (heart, carotid)	☐	F M S GP
Cholesterol, high	☐	F M S GP
Collagen disease (lupus)	☐	F M S GP
Diabetes	☐	F M S GP
Fatigue	☐	F M S GP
Fever blister / cold sores	☐	F M S GP
Gastrointestinal (stomach, colon)	☐	F M S GP
Genital, kidney, bladder	☐	F M S GP
Headaches / migraines	☐	F M S GP
Hearing impairment	☐	F M S GP
Hepatitis	☐	F M S GP
Herpes simplex / zoster	☐	F M S GP
High blood pressure	☐	F M S GP
HIV / AIDS	☐	F M S GP
Hormonal / Thyroid disease	☐	F M S GP
Muscle, bone, joint	☐	F M S GP
Neurologic (MS)	☐	F M S GP
Nose, Sinus, Throat	☐	F M S GP
Psychiatric (anxiety, depression)	☐	F M S GP
Resp (asthma, emphysema)	☐	F M S GP
Sexually transmitted disease	☐	F M S GP
Skin (acne, eczema)	☐	F M S GP
Tuberculosis	☐	F M S GP
Weak / numbness of arm / leg	☐	F M S GP
Weight changes sudden	☐	F M S GP