MORELAND
VISION
SOURCE!

Welcome to Our Office

To help us take better care of you, please provide us with the following information.

Name ______________________ Date ____________

Age ____________ Occupation ______________________

Date of last eye exam ______________

Do you wear glasses? ______________

How old are your glasses? ______________

Do you wear contact lenses? ______________

What type? ______________

How old is your current pair? ______________

What solutions do you use? ______________

Reason for today's visit ______________

____

Are you bothered by any of the following?

Headaches	yes	no
Double vision	yes	no
Dry / burning eyes	yes	no
Itchy eyes due to seasonal allergies	yes	no
Sensitivity to light	yes	no
Problems with glare	yes	no
Floaters or flashes of light	yes	no
Other kinds of discomfort with your eyes	yes	no

Do you have more than one pair of current glasses?	yes	no
Do you plan to look for new glasses today?	yes	no
Do you work on a computer?	yes	no
Do you engage in any sports, hobbies, or other activities where there are eye hazards?	yes	no
If you wear contacts, are you satisfied with vision and comfort?	yes	no
Are you interested in a "test drive of the latest in contact lenses?	yes	no
Do you have any questions about laser vision correction?	yes	no

Doctor Review ____________ ____________
Initial Date

Personal and Family Medical History

Does anyone in your **immediate family** have:

- ❑ Glaucoma ________
- ❑ Cataracts ________
- ❑ Macular Degeneration
- ❑ Diabetes ________
- ❑ High blood pressure ________

Do **you** have or have **you** had any of the following eye problems:

- ❑ Glaucoma
- ❑ Cataract
- ❑ Macular Degeneration
- ❑ Eye surgery/Injury
- ❑ Lazy eye or eye turn
- ❑ Other eye disease

Please indicate if **you** have any of the following health conditions:

Allergic/Immunologic
- ❑ Drug allergy
- ❑ Environmental allergy
- ❑ Rheumatoid arthritis
- ❑ Other
- ❑ Medications

____

Endocrine
- ❑ Non-insulin diabetes
- ❑ Insulin-dep. diabetes
- ❑ Thyroid dysfunction
- ❑ Other
- ❑ Medications

____

Musculoskeletal
- ❑ Fibromyalgia
- ❑ Muscular dystrophy
- ❑ Osteoarthritis
- ❑ Other
- ❑ Medications

____

Cardiovascular
- ❑ Heart disease
- ❑ Hypertension
- ❑ Stroke
- ❑ Other
- ❑ Medications

____

Gastrointestinal
- ❑ Ulcer
- ❑ Digestive
- ❑ Other
- ❑ Medications

____

Neurological
- ❑ Multiple sclerosis
- ❑ Epilepsy
- ❑ Other
- ❑ Medications

____

Constitutional
- ❑ Developmental disability
- ❑ Trauma
- ❑ Other
- ❑ Medications

____

Hematologic
- ❑ Anemia
- ❑ Leukemia
- ❑ Other
- ❑ Medications

____

Psychiatric
- ❑ Depression
- ❑ Other
- ❑ Medications

____

Ears, Nose & Throat
- ❑ Upper resp tract infect
- ❑ Other
- ❑ Medications

____

Skin Conditions
- ❑ Eczema
- ❑ Rosacea
- ❑ Other
- ❑ Medications

____

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Cigarette smoker
- ❑ Emphysema
- ❑ Other
- ❑ Medications

____

Primary Care Physician ______________ Last Visit ________

Specialist Physician ______________ Last Visit ________

Please list any **additional medications** you are currently taking, not listed above, including eye drops and over-the-counter medications.

____

____

Please list any medication allergies or sensitivities.

____

____