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invision eye care optometry

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619-295-4194

What is the purpose of today's visit:______________________________

Date of Last Eye Exam:______________________ Date of Last Medical Exam:______________________

List Any Major Surgeries:______________________________

Are you pregnant or nursing: No Yes

Allergies to Medications: No Yes

If Yes, please list:______________________

____

Currently Taking Medications: No Yes

If Yes, please list:______________________

____

____

Do you currently have or have you had any of the following:

Condition	No	Yes
Blurred vision	No	Yes
Loss of vision	No	Yes
Distorted vision	No	Yes
Loss of side vision	No	Yes
Double vision	No	Yes
Red eyes	No	Yes
Dry eyes	No	Yes
Mucous discharge	No	Yes
Sandy or gritty feeling	No	Yes
Excessive tears or watering	No	Yes
Itchy eyes	No	Yes
Foreign body sensation	No	Yes
Eye pain	No	Yes
Chronic eyelid infections	No	Yes
Sties or chalazion	No	Yes
Light flashes or floaters	No	Yes
Tired eyes	No	Yes

Do you currently have or have you had any of the following:

Condition	No	Yes
Thyroid disease	No	Yes
Allergies or hay fever	No	Yes
Chronic cough	No	Yes
Dry mouth	No	Yes
Asthma	No	Yes
Chronic bronchitis	No	Yes
Emphysema	No	Yes
Diabetes	No	Yes
Heart disease	No	Yes
High blood pressure	No	Yes
Vascular disease	No	Yes
Diarrhea or constipation	No	Yes
Kidney or bladder disease	No	Yes
Rheumatoid arthritis	No	Yes
Joint pain	No	Yes
Bleeding problems	No	Yes
Depression or anxiety	No	Yes

Please note any family history for the following conditions:

Condition	No	Yes	(relation)
Cataracts	No	Yes	__________
Glaucoma	No	Yes	__________
Macular degeneration	No	Yes	__________
Retinal detachment	No	Yes	__________
Crossed eyes	No	Yes	__________
Blindness	No	Yes	__________

Other:______________________

Please note any family history for the following conditions:

Condition	No	Yes	(relation)
Arthritis	No	Yes	__________
Diabetes	No	Yes	__________
Cancer	No	Yes	__________
Heart disease	No	Yes	__________
High blood pressure	No	Yes	__________
Lupus	No	Yes	__________
Thyroid disease	No	Yes	__________

The information below is kept strictly confidential; however, you may speak directly with the doctor if you prefer.

__________ **Yes, I would prefer to speak directly with the doctor concerning the issues below.**

Do you currently use or have you ever used any of the following:

Item	No	Yes
Tobacco products	No	Yes
Alcohol	No	Yes
Illegal drugs	No	Yes

Other:______________________

Have you been exposed to or infected with any of the following:

Condition	No	Yes
Gonorrhea	No	Yes
Hepatitis	No	Yes
Syphilis	No	Yes
HIV	No	Yes

Doctor Signature:______________________________ **Date:**__________

For Office Use Only	Rev by _________ Date _________	Rev by _________ Date _________	Rev by _________ Date _________