Welcome to All Family Vision Care!

Date _____

Date of Last Eye Exam _____ Dilated? Yes/No Referred By_____

Medical Information

How is your general health? _____

Do you take medications for any of these systems? (Please circle yes or no.)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine (glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary (skin)	Yes/No	Headaches	Yes/No
High blood pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Please explain _____

Diabetes Yes/No_____ Type _____ Date of diagnosis _____

Allergies to medication Yes/No Which? _____ Reactions? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other substance? _____

Current medication(s)_____

Have you had any operations? Yes/No Kind? _____ When? _____

Name of family doctor and/or primary care physician _____

Date of last visit _____ Date your blood pressure was last checked _____

Family History

High Blood Pressure Yes/No Relation _____ Macular Degeneration Yes/No Relation _____

Diabetes Yes/No Relation _____ Retinal Detachment Yes/No Relation _____

Glaucoma Yes/No Relation _____ Cataracts Yes/No Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind?_____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Retinal detachment?	Yes/No	Blurred vision?	Yes/No
Do you wear glasses?	Yes/No	Contact lenses?	Yes/No	Type	_____

Additional information _____

Signature:_____ Date:_____

Doctor Use Only

Reviewed by _____ ❍ No changes Date _____

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Reviewed by _____ ❍ No changes Date _____