WELCOME TO BARNES PROFESSIONAL EYE CARE!

Please complete/update the following confidential information. Let us know if you would like help in completing the form.

DEMOGRAPHICS

Last Name:_____ First Name:_____ M.I.:_____

Sex: M____ F____ Date of Birth: _____ ❒ Single ❒ Married ❒ Domestic Partner ❒ Widowed

Address:_____ City:_____ State: _____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____ Cell Phone: ( )_____

Email:_____ Occupation:_____ Employer:_____

Emergency Contact:_____ Relation: _____ Phone: ( )_____

MEDICAL INFORMATION

Last Eye Exam:_____ Eye Doctor/Office:_____

Last Medical Exam:_____ Primary Care Provider:_____

Do you wear Glasses? ❒ No ❒ Yes If yes, how old is your present pair of lenses?_____

Do you wear Contact lenses? ❒ No ❒ Yes If yes, which brand & how old is your present pair ?_____

Type of Contact Lenses: ❒ Rigid ❒ Soft ❒ Extended Wear ❒ Other Are they comfortable? ❒ Yes ❒ No

If you drive, do you have visual difficulty when driving? ❒ No ❒ Yes- Please explain:_____

Have you ever been diagnosed with:

❒ Glaucoma ❒ Cataracts ❒ Macular Degeneration ❒ Dry Eyes ❒ Keratoconus

❒ Retinal detachment/disease ❒ Eye infections, chronic ❒ Crossed eyes ❒ Lazy eye

Any other Eye Conditions/Problems? ❒ No ❒ Yes What kind?_____

Have you had any Eye Operations? ❒ No ❒Yes Type:_____ Date:_____

Have you had any Eye Injuries? ❒ No ❒Yes Type:_____ Date:_____

Do you have any Medication or Food Allergies? ❒ No ❒ Yes, Type & Reaction?_____

_____

Do you take ANY Medications? ❒ No ❒ Yes - Please list all Prescription, Non-prescription, routine use & as-needed use. Include oral contraceptives, Vitamins/Herbals:_____

_____

Past Medical History/Habits

List major injuries, surgeries and/or hospitalizations: _____

You may discuss the following personal information with the doctor if you prefer:

How much tobacco product do you use? ❒ None ❒ Type/amount/years: _____

How much Alcohol do you drink? ❒ None ❒ Type/amount/years: _____

How often do you use illicit drugs? ❒ None ❒ Type/amount/years: _____

Hobbies/Sports:

_____

_____

Do you currently, or have you ever had any Chronic/Serious problems in the following areas:

	NO	YES
EYES		
Loss of Vision	❒	❒
Loss of Side Vision	❒	❒
Blurred or Distorted Vision	❒	❒
Glare/Halos	❒	❒
Double Vision	❒	❒
Dryness	❒	❒
Excess Tearing/Watering	❒	❒
Mucous/Discharge	❒	❒
Eye Pain or Soreness	❒	❒
Itching	❒	❒
Burning	❒	❒
Sandy/Gritty/Foreign Body Sensation	❒	❒
Redness	❒	❒
Chronic Infection of Eye or Lid	❒	❒
Stye or Chalazion	❒	❒
Flashes/Floaters in Vision	❒	❒
Light Sensitivity	❒	❒
Tired Eyes	❒	❒
NEUROLOGICAL		
Headaches / Migraines	❒	❒
Seizures	❒	❒
Stroke/TIA	❒	❒
Neuromuscular/Movement Disorders	❒	❒
ENDOCRINE		
Diabetes	❒	❒
Hypo or Hyper-Thyroid	❒	❒
Other Gland disorders:		

	NO	YES
SKIN PROBLEMS, TYPE:	❒	❒
EARS, NOSE, MOUTH, THROAT		
Allergies/HayFever	❒	❒
Chronic Sinus Issues	❒	❒
Chronic Dry Throat/Mouth	❒	❒
RESPIRATORY		
Asthma / COPD / Emphysema	❒	❒
CARDIOVASCULAR		
High Blood Pressure	❒	❒
High Cholesterol	❒	❒
Cardiovascular problems	❒	❒
GASTROINTESTINAL		
Crohns/Inflammatory/Irritable Bowel	❒	❒
Heartburn, Chronic	❒	❒
GENITOURINARY	❒	❒
Kidney / Bladder / Prostate Problems	❒	❒
BONES/JOINTS/MUSCLES		
Muscle or Joint Pain	❒	❒
Rheumatoid / Lupus / Scleroderma	❒	❒
AUTOIMMUNE DISORDERS:	❒	❒
LYMPHATIC / HEMATOLOGIC		
Anemia	❒	❒
Bleeding Problems	❒	❒
IMMUNOLOGIC/INFECTIOUS DISEASE	❒	❒
Hepatitis_____ / HIV/AIDS	❒	❒
DEPRESSION/MENTAL HEALTH	❒	❒
ARE YOU PREGNANT OR NURSING?	❒	❒

If you answered YES to any of the above or have a condition not listed, please explain:

_____

FAMILY HISTORY ***Please note parents, grandparents, siblings, children; living or deceased, for the following:***

	NO	YES	RELATION		NO	YES	RELATION
Blindness	❒	❒	_____	Diabetes	❒	❒	_____
Cataracts	❒	❒	_____	Heart Disease	❒	❒	_____
Glaucoma	❒	❒	_____	High Blood Pressure	❒	❒	_____
Retinal Detachment/ Disease	❒	❒	_____	Rheumatoid Arthritis, Lupus, Autoimmune	❒	❒	_____
Macular Degeneration	❒	❒	_____	Thyroid Disease	❒	❒	_____

How did you select our office?

❒Referred by: _____ ❒ Family has been in ❒ Previous exam here ❒ Insurance Plan

❒ Phone book ❒ Internet search ❒ LA Fitness ❒ Other_____

Would you like more information on:

❒ Contact lenses	❒ Glasses	❒ Computer vision	❒ Floaters
❒ Orthorkeratology (corrective therapy)	❒ Progressives	❒ Astigmatism	❒ Macular Degeneration
❒ Keratoconus	❒ Sunglasses	❒ Laser Surgery	❒ Cataracts
	❒ Sports glasses	❒ Dry Eyes	❒ Glaucoma

SIGNED:_____ Date:_____

Signature of responsible party (parent/guardian if < 18 y.o.)