MERIDIAN EYECARE

Last Name_____First Name_____M_____DOB:___/___/___

M or F SSN_____/____/_____ Marital Status: Married / Single / Divorced / Widowed

Address_____City:_____ State:_____Zip:_____

Home Ph:( )_____ Work Ph:( )_____Cell Ph:( )_____

Employer/School:_____Occupation/School Grade_____

E-mail Address_____Sports/Hobbies_____

Emergency Contact:_____Relation_____Phone#( )_____

CASE HISTORY/REASON FOR VISIT:

Date of last Medical Exam:___/___/___ Primary Physician/Clinic_____

Date of Last Eye Exam:___/___/____ Clinic/Eye Doctor's Name_____

Do you wear glasses? Yes / No / All the time / Sometimes / Work only / Driving only

How old are your present glasses?_____Do you wear prescription Sun Wear? Y / N

Do you wear contacts? Yes No Type:_____ Solution Used_____

Wearing schedule: **Daily Overnight** Replacement schedule: **Daily 2 week Monthly**

Have you ever had eye injuries? Y / N Have you used eye medications? _____

Have you ever had eye surgeries? Yes No Why?_____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?
Cataracts: Yes / No Glaucoma: Yes / No Macular Degeneration: Yes / No

What are your visual symptoms? Please check all that apply:

[ ]Blurred Vision/Distance	[ ]Dry Eyes	[ ]Headaches	[ ]See Halos
[ ]Blurred Vision/Near	[ ]Red Eyes	[ ]Migraines	[ ]Droopy Lid
[ ]Double Vision	[ ]Watery Eyes	[ ]Loss of Vision	[ ]Itchy Eyes
[ ]Eye Strain	[ ]Wandering Eye	[ ]Crossed Eyes	[ ]Tired Eyes
[ ]Eye Infections	[ ]Mucus Discharge	[ ]Light Sensitive	[ ]Burning Eyes
[ ]Eye Pain/Soreness	[ ]Floaters or Spots	[ ]Flashes of Light	
[ ]Poor Color Vision	[ ]Poor Night Vision	[ ]Sandy/Gritty Feeling	

New patients only: Referred by_____

Patient Signature_____ **Date**_____

Please Turn over and complete the other side

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: __ None ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** __ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** __ None ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** __ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** __ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ None ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** __ None ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies (please list)** __ None Drug: Environmental:	**Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list physical reaction's to above allergies: _____

_____

Please list any medications and/or drugs that you are taking (including herbal) : See Attatched List: _____

1	For	6	For
2	For	7	For
3	For	8	For
4	For	9	For
5	For	10	For

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		WHO	DISEASE / CONDITION		WHO
Retinal Detachment:	Yes/No		Blindness:	Yes/No	
High Blood Pressure:	Yes/No		Cataracts:	Yes/No	
Diabetes:	Yes/No		Glaucoma:	Yes/No	
Cancer:	Yes/No		Crossed Eyes:	Yes/No	
Heart Disease:	Yes/No		Macular Degen:	Yes/No	
Thyroid Disease:	Yes/No		Lupus	Yes/No	

Reviewed by:

Dr _____ Date _____