Advanced Vision
Dr. Spencer Young, OD

General Information

Date: _____/_____/_____

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/Reading only/Driving only

How old are your present glasses: _____ Do you wear prescription Sun Wear: Yes/No

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

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

Have you ever had eye injuries? Yes No Which Eye?_____

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

Have you used eye medication? Yes No Why?_____

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

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?_____

Glaucoma: Yes/No When were you diagnosed?_____

Macular Degeneration: Yes/No When were you diagnosed?_____

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

In Example: [2] Eye Strain R L (B) This example indicates a moderate severity in both eyes

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

Please turn over and complete other side

Last Name_____First Name_____

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 _____