PerSpectacles Eyewear Gallery
Doctors Examination Form

Patient Name _____ Phone_____ Alt Phone _____

Address/
City/State/Zip_____

DOB_____M or F _____Social Security Number _____Parent or Guardian (if applicable)

Primary Care/Referring Dr. _____

Physician Name_____ Phone_____ Fax _____

City/State/Zip_____

Medical History Questionnaire
Health History

What is the main reason for today's Visit? _____

When was your last eye exam? _____

Medical Exam? _____

Past illnesses or injuries: _____

Past Surgeries: _____

Current medications: _____

Current eye-drops: _____

Medication allergies or sensitivities: _____

Specific allergies: _____

Eye History

Glaucoma	□Yes	□No	Mucous Discharge	□Yes	□No
Strabismus (crossed eyes)	□Yes	□No	Cataract	□Yes	□No
Drooping of Lid	□Yes	□No	Excess Tearing/Watering	□Yes	□No
Dryness	□Yes	□No	Color Blindness	□Yes	□No
Sandy or Gritty Feeling	□Yes	□No	Headaches	□Yes	□No
Floaters or Spots	□Yes	□No	Macular Degeneration	□Yes	□No
Tired Eyes	□Yes	□No	Glare/Light Sensitive	□Yes	□No
Amblyopic (lazy eye)	□Yes	□No	Burning	□Yes	□No

Blurred Vision Near	□Yes	□No	Blurred Vision Distance	□Yes	□No
Redness	□Yes	□No	Loss of Side Vision	□Yes	□No
Distorted Vision (halos)	□Yes	□No	Double Vision	□Yes	□No
Eye Pain or Soreness	□Yes	□No	Foreign Body Sensation	□Yes	□No
Loss of Vision	□Yes	□No	Infection of Eye or Lid	□Yes	□No
Fluctuating Vision	□Yes	□No	Itching	□Yes	□No
Detached Retina	□Yes	□No			

General Health Conditions

Fever	□Yes	□No	Respiratory (asthma)	□Yes	□No
Ear/Nose,/Throat	□Yes	□No	Weight Loss	□Yes	□No
Gastrointestinal	□Yes	□No	Cardiovascular (high BP)	□Yes	□No
Kidney	□Yes	□No	Anxiety or Depression	□Yes	□No
Neurological (M.S.)	□Yes	□No	Skin	□Yes	□No
Thyroid/Diabetes	□Yes	□No	Other Symptoms	□Yes	□No
Blood/Lymph	□Yes	□No	Muscles/Bones/Joints	□Yes	□No
Allergies	□Yes	□No	Headaches	□Yes	□No
Are you ?	□Pregnant		□Nursing		

Family History

Amblyopia	□Yes	□No	Macular Degeneration	□Yes	□No
Arthritis	□Yes	□No	Blindness	□Yes	□ No
Retinal Detachment	□Yes	□No	Cancer	□Yes	□No
Cataract(s)	□Yes	□No	High Blood Pressure	□Yes	□No
Diabetes	□Yes	□No	Glaucoma	□Yes	□No
Kidney Disease	□Yes	□No	Lupus	□Yes	□No
Color Blindness	□Yes	□No	Thyroid Disease	□Yes	□No
Stroke	□Yes	□No	Heart Disease	□Yes	□No
Strabismus (Eye Turning)	□Yes	□No			

If you answered yes to any of the previous questions or have a condition not listed,

please explain:_____

_____

SPECTACLE HISTORY

Do you use a computer? □Yes □No Hours per day? _____

Distance from eyes to screen?_____

Do you drive? □Yes □No Approx. number of miles per day?_____

Do you have problems with glare? □Yes □No

Do you have visual difficulty when driving? □Yes □No

Do you have problems with night vision? □Yes □No

Do you currently wear glasses? □Yes □No How many years?_____

Types of glasses □Full time □Part time □Distance □Close

Glasses Owned □Single Vision □Bifocals □Trifocals □Progressive
□Safety □Occupational □Backup

Do you wear sunglasses? □Yes □No Do your sunglasses have your current prescription? □Yes □No

Have you had trouble with glasses in the past? □Yes □No

Special Eyewear Needs

□ Computer (special prescription, anti-glare coating) □ Safety Glasses (gardening, woodworking, welding)

□ Occupational (mechanic, plumber, pilot) □Sports/Hobbies (racquet sports, motorcycling,)

Contact Lens History

If not a contact lens wearer, are you interested in trying contacts at this time? □Yes □No

Have you ever tried to wear contacts? □Yes □No

Do you currently wear contacts" □Yes □No How many years? _____

Type and brand of contacts? _____

How long have you worn them today?_____

How many hours wear per day? _____How many days per week? _____

On a scale of 1 (poor) to 10 (excellent) please rate the following:

Right lens: Comfort Distance vision Near vision

Left lens: Comfort Distance vision Near vision

Social History

_____

Current Occupation _____Years_____Employer_____

Do you use vitamins or nutritional supplements? □Yes □No

If so, what products do you use? _____

Do you drink alcohol? □No □Occasionally □Weekly □Daily

Do you smoke? □No □Occasionally □1/2 pack/day □1 pack/day □More

Do you use smokeless tobacco? □Yes □No

Do you use illegal drugs? □Yes □No

Hobbies/Interests_____

HIPPA Notice and Acknowledgment

I acknowledge that I have received and read the Notice of Privacy Practices □Yes □No

Our doctors routinely perform pupillary dilation to rule out retinal disease and check for cataracts, macular degeneration, glaucoma and other visual pathway diseases that may lead to loss of sight. There is an additional fee and this service may not be covered my some insurance plans. Please check one of the following:

□Please perform this test today □I will reschedule this test □I will follow the doctor's recommendation

Patient or Guardian Signature

_____ Date_____

Doctor Signature

_____ Date_____