Review of Systems

In order to care for your eyes more effectively please fill out the information below. Indicate if you are currently or if you have experienced any of the following problems. (If YES, please explain)

	NO	YES	EXPLAIN
EYES			
Loss of vision	☐	☐	____________
Distorted vision/ Halos	☐	☐	____________
Double vision	☐	☐	____________
Dryness	☐	☐	____________
Mucus discharge	☐	☐	____________
Gritty feeling	☐	☐	____________
Itching	☐	☐	____________
Burning	☐	☐	____________
Excess tearing	☐	☐	____________
Glare/light sensitivity	☐	☐	____________
Eye pain/ soreness	☐	☐	____________
Flashes/floaters	☐	☐	____________
NEUROLOGIC			
Headaches	☐	☐	____________
Migraines	☐	☐	____________
EARS/NOSE/THROAT			
Allergies	☐	☐	____________
Hayfever	☐	☐	____________
Sinus congestion	☐	☐	____________
SKIN PROBLEMS	☐	☐	____________
RESPIRATORY			
Asthma	☐	☐	____________
VASCULAR			
Diabetes	☐	☐	____________
High blood pressure	☐	☐	____________
GASTROINTESTINAL(stomach)	☐	☐	____________
GASTROURINARY (kidney/bladder)	☐	☐	____________
BONES/JOINTS/MUSCLES			
Rheumatoid Arthritis	☐	☐	____________
LYMPHATIC/HEMATOLOGICAL			
Anemia	☐	☐	____________
Bleeding problems	☐	☐	____________
ENDOCRINE (thyroid/ other glands)	☐	☐	____________
PSYCHIATRIC	☐	☐	____________

______________________________ Doctor's Signature

______________________ Review Date

DOWLING FAMILY EYE CARE 160 Grandview Ave., Honesdale PA

Welcome to Our Office

Name ______________________ Last eye exam ______________________

Street ______________________ Date of Birth ______________ Sex: M F

City ____________ State _____ Zip________ Spouse/Parent______________________

Home phone ______________________ Med. Insurance Co. ______________________

SSN. (optional) ______________________ Hobbies ______________________

Occupation ______________________ ______________________

Personal & Family Medical History

Indicate with **S=Self F=Family B=Both**

___High blood pressure ___Allergies

___Heart/Vascular ___Asthma

___Diabetes ___Head injury

___Thyroid Disease ___Cancer

___Multiple Sclerosis ___Arthritis

___Glaucoma ___Eye Injuries

___Eye diseases

Current Medications(Rx and Non-Rx)

Allergy Meds Y / N ______________

Diuretics(water pill) Y / N ______________

Blood pressure pills Y / N ______________

Oral contraceptives Y / N ______________

Sleeping tablets Y / N ______________

Diabetes meds Y / N ______________

Eye Drops Y / N ______________

Other ______________________

Are you under the care of a physician? Y / N

Name of physician ______________________

Date of Last Exam ______________________

Diagnostic Issues

Please list any complaints about wearing glasses or contacts. ______________________

____

____

Do you have multiple pairs of current glasses? Y/N

Do you work on a computer for long periods? Y/N

Could you benefit from thinner, lighter lenses? Y/N

Are you interested in a *trial* with the latest in contact lenses? Y/N

If you wear bifocals, are you bothered by restricted windows, lines or head tilting? Y/N

Are there times you'd rather not wear glasses? Y/N

If you wear contacts, are you satisfied with the vision and comfort? Y/N

Do you spend a lot of time outdoors? Y/N

Do You Experience...

Any discomfort with your eyes? Y /N

Problems with glare or reflection? Y /N

Sensitivity to light? Y /N

Floaters or flashes of light? Y /N

Headaches? Y /N

How did you hear about our office?

Advertisement? ______________________ Friend/relative ______________________

Previous patient ______________________ Participating eye care plan ______________

Dilation (using drops to widen the pupil) is necessary to adequately inspect the periphery of the eye for presence of tumors, detachments, and other conditions. It is recommended every 3-4 years as part of a complete eye examination. Dilation may temporarily affect your ability to read and will increase your light sensitivity for up to 6 hours. Please indicate your decision:

I accept dilation / I decline dilation / I would like to reschedule dilation.