DOWLING FAMILY EYE CARE 160 Grandview Ave., Honesdale PA

Welcome to Our Office

Name _____ Last eye exam _____

Street _____ Date of Birth _____

City _____ State _____ Zip _____ Gender M F Non-binary

Home phone _____ Spouse/Parent _____

Cell phone _____ Med. Insurance Co. _____

Email _____ Hobbies _____

SSN. (optional) _____ 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 _____

Pharmacy _____

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.

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	☐	☐	_____