ClearVue Eye Care OF Roseville
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Name_____

This is your opportunity to tell us about your vision and medical history.

WHAT IS THE MAIN REASON FOR YOUR VISIT ?_____

WHAT METHODS OF VISION IMPROVEMENT ARE YOU CONSIDERING ? ☐ LASIK ☐ GLASSES ☐ CONTACT LENSES

WHAT CONCERNS DO YOU HAVE REGARDING LASER VISION CORRECTION ? ☐ SAFETY ☐ COST ☐ AM I A GOOD CANDIDATE?

DO YOU USE THE COMPUTER MORE THAN 2 HOURS PER DAY ? ☐ YES ☐ NO

DO YOU SMOKE REGULARLY ? ☐ YES ☐ NO DO YOU DRINK ALCOHOL REGULARLY ? ☐ YES ☐ NO

INSURANCE REGULATIONS REQUIRE THAT WE RECORD YOUR WEIGHT AND HEIGHT: WEIGHT_____LBS HEIGHT_____FT_____IN

MY PRIMARY CARE PHYSICIAN IS:_____MY PREFERRED PHARMACY IS:_____

YOUR MEDICAL HISTORY: DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR SYMPTOMS?

☐ YES ☐ NO DIABETES
☐ YES ☐ NO HYPERTENSION
☐ YES ☐ NO BLEEDING DISORDERS (HEMOPHILIA)
☐ YES ☐ NO STROKE
☐ YES ☐ NO CARDIOVASCULAR
☐ YES ☐ NO RESPIRATORY (ASTHMA, EMPHYSEMA)
☐ YES ☐ NO HIV
☐ YES ☐ NO THYROID PROBLEMS
☐ YES ☐ NO MUSCLES, BONES, JOINT (ARTHRITIS)
☐ YES ☐ NO HEPATITIS
☐ YES ☐ NO TUBERCULOSIS
☐ YES ☐ NO SARCOIDOSIS / LUPIS
☐ YES ☐ NO COLD SORES
☐ YES ☐ NO ALLERGIC / IMMUNOLOGIC
☐ YES ☐ NO WEAKNESS OR PARALYSIS
☐ YES ☐ NO FEVER
☐ YES ☐ NO RAPID WEIGHT LOSS / GAIN

OTHER HEALTH PROBLEMS ?_____

YOUR EYES: ARE YOU PRESENTLY HAVING ANY OF THESE SYMPTOMS?

☐ YES ☐ NO BLURRED OR DISTORTED VISION
☐ YES ☐ NO SUDDEN LOSS OF VISION
☐ YES ☐ NO DOUBLE VISION
☐ YES ☐ NO LOSS OF SIDE VISION
☐ YES ☐ NO REDNESS
☐ YES ☐ NO EYE PAIN
☐ YES ☐ NO DISCHARGE (WATERY, MUCUS)
☐ YES ☐ NO SANDY, GRITTY FEELING
☐ YES ☐ NO BURNING OR STINGING
☐ YES ☐ NO ITCHING
☐ YES ☐ NO FLASHES AND/OR FLOATERS
☐ YES ☐ NO GLARE, LIGHT SENSITIVITY, OR HALOS
☐ YES ☐ NO BUMP ON EYELID OR DROOPY EYELID

FOR DRY EYE AND ALLERGY SUFFERERS:

WHAT TREATMENT OPTIONS (IF ANY) HAVE YOU TRIED TO RELIEVE YOUR SYMPTOMS?

☐ ARTIFICIAL TEARS ☐ PRESCRIPTION EYE DROPS
☐ PUNCTAL PLUGS ☐ SUPPLEMENTS / VITAMINS

DO ANY OF YOUR BLOOD RELATIVES HAVE HEALTH PROBLEMS IN ANY OF THE FOLLOWING AREAS:

☐ YES ☐ NO BLINDNESS
☐ YES ☐ NO GLAUCOMA
☐ YES ☐ NO MACULAR DEGENERATION
☐ YES ☐ NO CATARACTS
☐ YES ☐ NO LAZY EYE
☐ YES ☐ NO RETINAL DETACHMENT

HAVE YOU HAD ANY OF THE FOLLOWING?

☐ YES ☐ NO EYE SURGERY
☐ YES ☐ NO EYE INJURY
☐ YES ☐ NO EYE DISEASE

OTHER EYE PROBLEMS ? _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS ? ☐ YES ☐ NO If yes, please list:_____

LIST CURRENT MEDICATIONS (INCLUDING TABLETS, INJECTIONS, EYE DROPS, BIRTH CONTROL, HORMONES, AND ANTIHISTAMINES)

The above information regarding my personal medical history is true and correct and up-to-date according to the best of my knowledge.

_____
Patient Signature

_____
Date

Subsequent History Reviews

_____/_____	_____/_____	_____/_____	_____/_____
Initial / Date	Initial / Date	Initial / Date	Initial / Date
☐ no change	☐ no change	☐ no change	☐ no change
☐ changes made	☐ changes made	☐ changes made	☐ changes made