

Patient Legal Name:

East Main Vision Clinic

Birth Date:

Dr. Joseph D. Day O.D.

Nickname:

Please fill out and bring to your appointment

Family Social & Health History:

Indicate family member: (mom, dad, uncle, grandmother, etc.)

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> glaucoma | <input type="checkbox"/> cancer | <input type="checkbox"/> genetic disorder |
| <input type="checkbox"/> macular degeneration | <input type="checkbox"/> diabetes | <input type="checkbox"/> high blood pressure |
| <input type="checkbox"/> amblyopia (lazy eye) | <input type="checkbox"/> dementia | <input type="checkbox"/> psychiatric problems |

Patient Social History:

Employer:

Occupation:

Do you work on the computer: Yes / No

Number of Hours on Computer:

Substance Use:

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Tobacco | frequency / type |
| <input type="checkbox"/> Alcohol | drinks per day/week |
| <input type="checkbox"/> Addiction | Drug / Alcohol rehabilitation undertaken ? Yes / No |

Recreational Activities:

Hobbies / Interests

- | | | |
|--|---|--|
| <input type="checkbox"/> baseball / softball | <input type="checkbox"/> hiking | <input type="checkbox"/> art work |
| <input type="checkbox"/> basketball | <input type="checkbox"/> motorcyclist | <input type="checkbox"/> collecting |
| <input type="checkbox"/> bicycling | <input type="checkbox"/> running / walking | <input type="checkbox"/> computer / internet use |
| <input type="checkbox"/> boating | <input type="checkbox"/> R.V. traveling | <input type="checkbox"/> photography |
| <input type="checkbox"/> camping | <input type="checkbox"/> scuba diving | <input type="checkbox"/> reading |
| <input type="checkbox"/> fishing | <input type="checkbox"/> soccer | <input type="checkbox"/> sewing / hand work |
| <input type="checkbox"/> flying (pilot), | <input type="checkbox"/> snow boarding / skiing | <input type="checkbox"/> wood working |
| <input type="checkbox"/> golf | <input type="checkbox"/> tennis | |
| <input type="checkbox"/> gymnastics | <input type="checkbox"/> travel | |

Others activities or interests not specified:

Eye Symptoms / Problems / Activities:

- | | |
|---|--|
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> eye protection needed |
| <input type="checkbox"/> dry feeling eyes | <input type="checkbox"/> hard to use bifocals |
| <input type="checkbox"/> glare and reflections bother | <input type="checkbox"/> hard to see computer screen |
| <input type="checkbox"/> irritated / sore eyes | <input type="checkbox"/> double vision |
| <input type="checkbox"/> sensitive to bright lights | <input type="checkbox"/> headaches |
| <input type="checkbox"/> red eyes | <input type="checkbox"/> other: |

Currently Wear Glasses for :

Currently Wear Contact Lenses:

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> reading | <input type="checkbox"/> part time |
| <input type="checkbox"/> far vision | <input type="checkbox"/> full time |
| <input type="checkbox"/> sun glasses | <input type="checkbox"/> over-night wear / day time wear |

Medications: (Include non-prescription drugs / preparations, and eye drops used)

(Please attach a separate sheet if needed)

Name of medication:	Intended therapeutic use:
1	
2	
3	
4	
5	
6	
7	
8	

I am interested in getting information on:

- | | |
|---|---|
| <input type="checkbox"/> LASIK refractive surgery | <input type="checkbox"/> Contacts |
| | <input type="checkbox"/> Non-Surgical correction of nearsightedness |