

Southwest Plaza Vision Associates

Welcome! We appreciate you selecting our office for your eye care needs. We will do everything possible to insure your satisfaction.

NAME _____ DATE _____ DATE OF BIRTH _____ AGE _____
 GENDER _____ PHONE _____ SOC.SEC. _____
 ADDRESS _____ CITY/STATE/ZIP _____
 OCCUPATION _____ EMPLOYER _____ WORK PHONE _____
 IF CHILD, PARENT'S NAME _____ DATE OF LAST EXAMINATION _____
 I PREFER TO BE CALLED _____ EMAIL _____ DO
 YOU WEAR GLASSES? _____ CONTACT LENSES? _____ HOW DID YOU LEARN ABOUT OUR OFFICE? _____ WHO
 MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

WHAT BRINGS YOU TO OUR OFFICE TODAY?

ROUTINE CHECK UP "aaaaaaa" LOST OR BROKEN GLASSES _____ CONTACT LENS PROBLEMS _____
 5 (' 1 (6 6 LOS' OR BOIN CONTACT LENSES " _____ FLASHES OF LIGHT "aaaaaaaaa"
 FLOATERS "a" _____ DISTANCE VISION BLURRY _____ NEAR VISION BLURRY _____
 JGCFCEJGU "aaaaaaa" EYES ITCH, BURN, WATER _____ PERIPHERAL VISION PROBLEMS _____
 OTHER _____

PLEASE TELL US ABOUT YOUR HEALTH HISTORY:	YOU (WHAT?)	MEDICATIONS:
CONSTITUTIONAL: Cancer, Fever, Weight Loss, Weight Gain, Fatigue, etc.		
EAR, NOSE, THROAT: Allergies, Sinus, Cough, Dry Mouth/Throat, etc.		
CARDIOVASCULAR: High Blood Pressure, Heart Surgery, Vascular Disease, etc.		
RESPIRATORY: Asthma, Bronchitis, Emphysema, COPD, etc.		
GENITAL, KIDNEY, BLADDER: Kidney Stones, etc.		
MUSCLES, BONES, JOINTS: Arthritis, Joint Pains, Head or Neck Injury, etc.		
SKIN:		
NEUROLOGICAL: Headaches, Migraines, Seizures, etc.		
PSYCHIATRIC: Depression, Anxiety, Insomnia, etc.		
ENDOCRINE: Thyroid, Diabetes, etc.		
BLOOD/LYMPH: Anemia, Cholesterol, Bleeding Problems, etc.		
ALLERGIC/IMMUNOLOGIC: Allergies, Rheumatic, HIV, Lupus, etc.		
GASTROINTESTINAL: Reflux, etc.		
OTHER:		
OCULAR: Injuries, Infections, Surgeries, Diseases, etc.		

ARE YOU ALLERGIC TO ANY MEDICATIONS? _____ IF YES, WHAT? _____

ARE YOU PREGNANT OR NURSING? _____

ANY HISTORY OF THE FOLLOWING IN ANY FAMILY MEMBER? (parents, grandparents, siblings, children)	YES (relationship)	ANY HISTORY OF THE FOLLOWING IN ANY FAMILY MEMBER? (parents, grandparents, siblings, children)	YES (relationship)
Poor Vision		Cancer	
Blindness		Diabetes	
Eye Turn (Strabismus)		High Blood Pressure	
Lazy Eye (Amblyopia)		Heart Disease	
Glaucoma		Thyroid Disease	
Cataracts		Other Inherited Diseases	
Macular Degeneration		If yes, what disease?	
Retinal Detachment			

Signed: _____ **Date:** _____