Name ______________________________ Today's Date ______________
Address ______________________________ Home Phone: ______________
______________________________ Cell Phone: ______________
Birthdate ____________ Social Security # ____________ Work Phone: ______________
Name of Medical Doctor ______________________________ Email: ______________
Medical Insurance ______________________________ Last Eye Exam: ______________
Vision Insurance ______________________________ Last Medical Exam: ______________

Medical History

List any medications you take (including oral contraceptives, over the counter medications and home remedies:)

____

List all medication allergies and reactions: ______________________________

List all major injuries or operations to your eyes: ______________________________

____

List any of the following that you have had:

✓ crossed eyes ✓ lazy eye ✓ glaucoma ✓ retinal disease ✓ cataracts ✓ eye infections
✓ eye injuries ✓ macular degeneration

Have you considered:

✓ Contact Lenses
✓ Sun Glasses or Clip-ons
✓ Progressive Lenses
✓ Refractive Surgery

Do you have a problem with any of the following:

✓ Glare from headlights
✓ Brightness during the day
✓ Computer Lenses
✓ Intermediate Vision (i.e. dashboard, store shelves, etc.)

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) *for following conditions:*

DISEASE/CONDITION	*RELATIONSHIP TO YOU*
✓ Blindness	______________
✓ Cataract	______________
✓ Crossed Eyes	______________
✓ Glaucoma	______________
✓ Macular Degeneration	______________
✓ Retinal Detachment/Disease	______________
✓ Arthritis	______________
✓ Cancer	______________
✓ Diabetes	______________
✓ Heart Disease	______________
✓ High Blood Pressure	______________
✓ Kidney Disease	______________
✓ Lupus	______________
✓ Thyroid Disease	______________

- ✓ Other____________________ ____
- ✓ Other____________________ ____
- ✓ Other____________________ ____

NOBLE VISION CENTER

Social History

Do you drive? ✓ no ✓ yes If yes, do you have difficulty when driving? ✓ no ✓ yes If yes, please describe: ____________________

Do you use tobacco products? ✓ no ✓ yes If yes, type/amount/how long: ____________________

____________________ Do you drink alcohol? ✓ no ✓ yes If yes,

occasionally, moderately, frequently

Vocation (What do you do) ____________________

Hobbies ____________________

Sports or Outdoor Activities ____________________

Review of Systems

Constitutional None____
- ✓ Development Disability
- ✓ Weight Loss/Gain
- ✓ Fever
- ✓ Fatigue
- ✓ Cancer

Ear, Nose, Mouth, Throat None____
- ✓ Upper Respiratory Tract Infection
- ✓ Sinus Congestion
- ✓ Dry Throat/Mouth

Vascular/Cardiovascular None____
- ✓ Heart Disease
- ✓ High Cholesterol
- ✓ High Blood Pressure
- ✓ Stroke

Respiratory None____
- ✓ Asthma
- ✓ Bronchitis
- ✓ Emphysema

Integumentary (skin) None____
- ✓ Eczema
- ✓ Rosacea

Neurological None____
- ✓ MS (Multiple Sclerosis)
- ✓ Headaches
- ✓ Migraines
- ✓ Seizures

Eyes None____
- ✓ Muscle Surgery
- ✓ Cataract
- ✓ Glaucoma
- ✓ Loss of Vision
- ✓ Macular Degeneration
- ✓ Double Vision
- ✓ Loss of Side Vision
- ✓ Distorted Vision/Halos
- ✓ Dryness
- ✓ Mucous Discharge
- ✓ Redness
- ✓ Sandy or Gritty Feeling
- ✓ Itching
- ✓ Burning
- ✓ Foreign Body Sensation
- ✓ Excess Tearing/Watering
- ✓ Glare/Light Sensitivity
- ✓ Eye Pain or Soreness
- ✓ Chronic Infection of Eye or Lid
- ✓ Styes or Chalazion
- ✓ Flashes/Floaters in Vision
- ✓ Tired Eyes

Endocrine None____
- ✓ Thyroid/Other Glands
- ✓ Diabetes • insulin dependent
- ✓ Diabetes • non-insulin dependent

Gastrointestinal None____
- ✓ Crohn's
- ✓ Colitis
- ✓ Ulcer

Genitourinary None____
- ✓ Urinary Tract Infection
- ✓ Kidney Ailments

Bones/Joints/Muscles None____
- ✓ Rheumatoid Arthritis
- ✓ Muscle Pain
- ✓ Joint Pain
- ✓ Muscular Dystrophy

Lymphatic/Hematologic None____
- ✓ Anemia
- ✓ Bleeding Problems

Allergic/Immunologic None____
- ✓ Lupus
- ✓ Hay Fever
- ✓ ____________________
- ✓ ____________________
- ✓ ____________________

Psychiatric None____
- ✓ ____________________
- ✓ ____________________