BRAESWOOD VISION

"…we take your eyes to heart"

Lon D. Cartwright, O.D.

WELCOME !

Today's Date _____
Patient Name _____
Spouse / Parent's Name _____
Dependents _____
Address _____
City _____ State _____ Zip _____
Cell # _____ Home # _____
Work # _____ Ext _____
E-mail Address_____
DOB _____ Age _____ Sex M F
Social Security Number _____
Employer or School _____
Occupation or Grade _____
Emergency Contact _____ Ph # _____

MEDICAL HISTORY

CONDITION	Type	Self	Anyone in your family?
Asthma / COPD	_____	No Yes	Dad / Mom / Bro / Sis
Arthritis	_____	No Yes	Dad / Mom / Bro / Sis
Autoimmune	_____	No Yes	Dad / Mom / Bro / Sis
Cancer	_____	No Yes	Dad / Mom / Bro / Sis
Diabetes - Type:	_____	No Yes	Dad / Mom / Bro / Sis
Heart Dis	_____	No Yes	Dad / Mom / Bro / Sis
High Cholesterol	_____	No Yes	Dad / Mom / Bro / Sis
Hypertension	_____	No Yes	Dad / Mom / Bro / Sis
Neurological Dis	_____	No Yes	Dad / Mom / Bro / Sis
Psychological	_____	No Yes	Dad / Mom / Bro / Sis
Skin Dis	_____	No Yes	Dad / Mom / Bro / Sis
Thyroid Dis	_____	No Yes	Dad / Mom / Bro / Sis

OCULAR HISTORY

Blindness	No Yes	Dad / Mom / Bro / Sis
Cataracts	No Yes	Dad / Mom / Bro / Sis
Glaucoma	No Yes	Dad / Mom / Bro / Sis
Macular Degeneration	No Yes	Dad / Mom / Bro / Sis
Retinal Disease	No Yes	Dad / Mom / Bro / Sis
Retinal Detachment	No Yes	Dad / Mom / Bro / Sis

List any eye injuries _____
List any eye surgeries _____
List any other medical or eye condition not stated above:
_____

CURRENT MEDICATIONS
Prescription or Non-Prescription and Dosage

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

For additional space, use back side of this form.

Are you allergic to any medication? No Yes
If yes, please list _____

Do you have other allergies? (latex, seasonal, etc.) No Yes
If yes, please list _____

Date of Last Eye Exam _____

Where? _____

What is the major purpose of today's visit? _____
_____

Do you currently wear glasses? No Yes
If so, do you wear them
- ☐ Distance only
- ☐ Near only
- ☐ Full time

Are you interested in updating your frame? No Yes

Do you currently wear contact lenses? No Yes
If so, what kind? _____
What solutions do you use? _____
Do you ever sleep with your contacts on? No Yes

If you do not wear contact lenses, are you interested in getting them? No Yes

Do you work at a computer for long periods of time? No Yes
Are you interested in refractive surgery? No Yes

Please, check all that apply in relation to your eyes.

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Watery eyes
- ☐ Dryness
- ☐ Gritty feeling
- ☐ Sore eyes
- ☐ Eye strain
- ☐ Headaches
- ☐ Nausea
- ☐ Fainting or dizziness
- ☐ Double vision
- ☐ Spots floating in vision
- ☐ Flashes of light
- ☐ Sudden loss of vision
- ☐ Sensitivity to light
- ☐ Glare or reflections
- ☐ Blurry distance vision
- ☐ Blurry near vision
- ☐ Trouble reading at work or school
- ☐ Trouble seeing at night
- ☐ Uncomfortable glasses
- ☐ Uncomfortable contacts

If you are a new patient, whom may we thank for referring you to us? _____