Shores Optometry East
3923 Pine Grove Rd
Fort Gratiot MI 48059
shoresoptometryeast.com

Patient Information

Patient Name:_____Today's Date: _____
Date of birth: _____ Last 4 of SSN:_____ Gender: ___Male ___Female ___Declined to Answer
Address:_____
Home phone:_____Cell phone:_____Work phone:_____
Employer name and address:_____
_____
Primary Care Physician: _____Phone Number: _____
Date and Location of Last Eye Exam: _____
Emergency Contact Name: _____Phone:_____

Patient Medical Information

Do you smoke/use tobacco products? __Yes __ No If yes, type/amount/how long? _____
Do you use alcohol? __Yes __No If yes, type/amount/how long? _____
Do you use illegal drugs? __Yes __No If yes, type/amount/how long?_____
Have you ever been exposed to or infected with: __Gonorrhea __Hepatitis __HIV __Syphilis __Herpes

Review of Systems

Many medical conditions and medications affect the eyes. Please help the doctor by filling out your medical history as completely as possible. Check any conditions that apply to you:

	Yes	No		Yes	No		Yes	No
Respiratory			**Gastrointestinal**			**Musculoskeletal Conditions**		
Asthma			Diarrhea			Rheumatoid Arthritis		
COPD			Constipation			Osteoarthritis		
Emphysema			Other:			Other:		
Other:			**Immune**			**Ear/Nose/Throat**		
Skin Conditions			Lupus			Sinus		
Eczema			Other:			Chronic Cough		
Rosacea			**Neurological Disorders**			Other:		
Other:			Migraines			**Genitourinary**		
Endocrine Disorder			Headaches			Kidney		
Diabetes			Multiple Sclerosis			Bladder		
Thyroid disorder			Head Injury			Genitals		
Other:			Seizures			Other:		
Cardiovascular			Other:			**Psychiatric**		
High blood pressure			**Lymphatic/Hematologic**			Anxiety		
Heart Condition			Anemia			Depression		
High Cholesterol			Bleeding Problems			Other:		
Stroke			Blood Disorder			**Seasonal Allergies**		
Other:			Other:			What season:		

Are you pregnant? Yes ____ No ____ If yes, how many months? _____

Patient Eye History

	Yes	No		Yes	No
Loss of Vision			Burning		
Blurred Vision			Foreign Body Sensation		
Distorted Vision/Halos			Excess Tearing/Watering		
Loss of Side Vision			Glare/Light Sensitivity		
Double Vision			Eye Pain/Soreness		
Dryness			Chronic Infection of Eye or Lid		
Mucous Discharge			Sties or Chalazion		
Redness			Flashes		
Sandy/Gritty Feeling			Floaters		
Itching			Tired Eyes		

Have you had any eye injuries, surgeries, or eye diseases? ___ Yes ___ No If yes, please list:_____

_____

_____

Have you had any surgeries other than having to do with the eye? ___ Yes ___ No If yes, please list:

_____

_____

Are you currently being treated for any medical condition? ___ Yes ___ No If yes, please list:

_____

_____

_____

Please list (or attach list) any current medications, prescription, over the counter, vitamins, or supplements?

_____

_____

_____

_____

_____

_____

Do you have any allergies to medications? ___ Yes ___ No If yes, please list: _____

_____

_____

_____

Family History

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

	Yes	No	Who/explain
Glaucoma			
Blindness			
Crossed Eyes			
Retinal Detachment			
Macular Degeneration			
Heart Disease			
Diabetes			
Other:			

Do you wear contacts? If so, what kind/cleaner? _____

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How long do you wear them?_____
Do you use a computer? _____ If so, how many hours per day? _____