

∞ WELCOME TO OUR OFFICE ∞

Your physical health, occupation, hobbies, and lifestyle affect your eyes in many ways. Please answer the following questions to help Dr. Rieger, Dr. Willenbring and the staff better address your eye health and vision needs. Thank You!

Today's Date: \_\_\_\_\_

Patient Name:  Mr.  Mrs.  Miss  Dr. \_\_\_\_\_ Nickname: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female Work Phone: \_\_\_\_\_

Guardian: \_\_\_\_\_ Social Security #: \_\_\_\_\_ E-mail: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Date of Last Physical/Exam: \_\_\_\_\_

Date of Last Eye Exam: \_\_\_\_\_ By Dr. \_\_\_\_\_

Occupation: \_\_\_\_\_ Employed By: \_\_\_\_\_

Please list any occupational vision requirements you may have: \_\_\_\_\_

\_\_\_\_\_

Please list any hobbies/sports/recreational activities: \_\_\_\_\_

\_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Reason for today's visit:  Annual Exam  Glasses  Contacts  Eye Health  Referred  Other \_\_\_\_\_

**INSURANCE INFORMATION**

VISION INSURANCE INFORMATION	
Carrier _____	
Member Name _____	D.O.B. _____
Member ID # _____	Group # _____

MEDICAL INSURANCE INFORMATION	
Carrier _____	
Member Name _____	D.O.B. _____
Member ID # _____	Group # _____

**MEDICAL HISTORY**

MEDICATIONS AND ALLERGIES	
Please list <b><u>ALL</u></b> medications, including over-the-counter meds:	Please list <b><u>ANY</u></b> allergies (medication or environmental):

Please any **major** medical conditions : \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you are female, are you pregnant or nursing?  Yes  No

## REVIEW OF SYSTEMS

Please circle any of the following medical conditions you may have:

EYES/OCULAR	RESPIRATORY	CONSTITUTIONAL
Loss of Vision Blurred Distance Vision Blurred Near Vision Distorted Vision/Halos Loss of Side Vision Double Vision Night Vision Problems Color Vision Problems Dryness Mucous Discharge Redness Sandy or Gritty Feeling Itching Burning Excess Tearing/Watering Glare/Light Sensitivity Eye Pain or Soreness Chronic Infection of Eye or Lid Sties/Chalazion Flashes/Floaters in Vision Tired Eyes Other: _____ _____ _____	Asthma Chronic Bronchitis Emphysema	Fever Recent Weight Gain/Loss
	VASCULAR/CARDIOVASCULAR	INTEGUMENTARY (SKIN)
	Diabetes Heart/Chest Pain High Blood Pressure Vascular Disease	Rash/Itching New Moles/Growth
	GASTROINTESTINAL	NEUROLOGICAL
	Diarrhea Constipation	Headaches Migraines Dizziness Seizures Numbness/Tingling Sensation
	GENITOURINARY	ENDOCRINE
	Kidney Stones Difficult/Painful Urination Incontinence	Thyroid Problems Other Gland Problems
	BONES/JOINTS/MUSCLES	EARS/ NOSE/ MOUTH/ THROAT
	Rheumatoid Arthritis Muscle Pain/Weakness Joint Pain/Weakness	Allergies/Hay Fever Sinus Congestion Runny Nose Post-Nasal Drip Chronic Cough Dry Throat/Mouth
	LYMPHATIC/HEMATOLOGIC	PSYCHIATRIC
	Anemia Bleeding/Bruising Problem	Memory Loss/Confusion Nervousness/Panic Attacks Insomnia
	ALLERGIC/IMMUNOLOGIC	
	Eczema Immunological Disease	

## FAMILY HISTORY

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

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cataract	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crossed Eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other: _____				

## SOCIAL HISTORY

*This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.*

Yes, I would prefer to discuss my Social History information directly with my doctor. (Check Box)

Do you drive?  Yes  No → If yes, do you have visual difficulty when driving?  Yes  No → 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, type/amount/how long: \_\_\_\_\_  
 Do you use illegal drugs?  No  Yes If yes, type/amount/how long: \_\_\_\_\_

***This information has been reviewed by me and is complete and up to date. Sign and date once for each subsequent visit.***

Signed \_\_\_\_\_ Date \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_ Signed \_\_\_\_\_ Date \_\_\_\_\_