Welcome to Norton Eye Care

Date: _______/_______/_______

Patient Information

Name: ________________________________ Nickname: _____________________________

Address:____

Apt #: __________ City: __________________________ State: ________ Zip: __________

Cell Phone: _________________________ Home Phone: _____________________________

Work Phone: ________________________ Email Address: ____________________________

Preferred Communication: ☐Phone ☐Email

Date of Birth: ______/_______/_______ Social Security Number: _______-_______-______

Assigned Gender: ☐Male ☐Female Marital Status: ☐Single ☐Married ☐Other

Current Gender Identity: ☐Male ☐Female ☐Other______________________

Preferred Pronouns: ☐He/Him ☐She/Her ☐They/Them ☐Other ________________

Guardian: ____________________________________ Relationship: ___________________

Phone Number: ____________________

Emergency Contact: ____________________________ Relationship: ___________________

Phone Number: ____________________

How did you hear about us? ____

Primary Care Physician: ____________________________________

Previous Eye Doctor: ______________________________ Last Eye Exam: _____/_____/_____

Social History

Drink: ☐Yes ☐No **If yes**; Frequency: ______________ Amount: ______________________

Smoke: ☐Yes ☐No **If yes**; ☐ Marijuana ☐ Tobacco Frequency:_________ Amount:_________

Visual Needs Assessment

Employer: ____________________________Occupation: _______________________________

Sports/Hobbies: ____

Hours of Computer Usage/ Day: _______ Hours Outside/ Day: ______

Hours Before Reading Fatigue: __________ Daily Driving Distance: __________

I wear: (Check all that apply)

☐ Glasses Full Time ☐ Bifocal ☐ Progressive (No-line Bifocal) ☐ Driving/ Distance Glasses

☐ Reading Glasses ☐ Prescription Sunglasses ☐ Non-Prescription Sunglasses ☐ Safety Glasses

☐Contact Lenses Contact Brand: ____

How long do you wear your contacts before you throw them away? _____________________

Do you sleep in your contacts? ☐Yes ☐No

Contact Lens Solution: ☐Opti-Free ☐BioTrue ☐Clear Care ☐Renu ☐Generic

☐ Other: _______________________

Personal Medical History

Major Injuries/Surgeries: ____

____

Medications: ____

____

Eye Drops: ____

Allergies: Drug: ____

Environmental Allergies: ____

____

Latex: Yes/ No

Personal Medical History (Continued)

Constitutional **Neurologic** **Cardiovascular** **Respiratory**

☐Cancer
☐Developmental Disabilities
☐Fatigue
☐Other

☐MS
☐Epilepsy
☐Cerebral Palsy
☐Tumor
☐Migraine
☐Autism Spectrum Disorder

☐High Blood Pressure
☐Stroke/CVA
☐Heart Disease
☐Vascular Disease
☐Congestive Heart Failure

☐Asthma
☐Bronchitis
☐Emphysema
☐Sleep Apnea
☐Chronic Obstruction

Ear/Nose/Throat
☐Hearing Loss
☐Sinusitis
☐Dry Mouth
☐Laryngitis

Psychiatric
☐Depression
☐ADD/ADHD
☐Anxiety
☐Bipolar Disorder

Genitourinary
☐Kidney Disease
☐Prostate Disease
☐STD
☐Pregnant/ Nursing
☐Prostate Hypertrophy

Integumentary
☐Eczema
☐Rosacea
☐Psoriasis
☐Cold Sores
☐Shingles

Endocrine
☐Type 2 Diabetes Mellitus
☐Type 1 Diabetes Mellitus
☐Herpes Simplex
☐Thyroid Dysfunction
☐Hormonal Dysfunction

Gastrointestinal
☐Crohn's
☐Colitis
☐Ulcer
☐Acid Reflux

Musculoskeletal
☐Osteoarthritis
☐Arthritis
☐Fibromyalgia
☐Muscular Dystrophy
☐Celiac Disease
☐Osteoporosis
☐Gout
☐Ankylosing Spondylitis

Hematologic/Lymphatic
☐Anemia
☐Ulcer
☐High Cholesterol

Autoimmune
☐Rheumatoid arthritis
☐Sjogren's
☐Lupus

Personal Ocular/ Eye History

☐ Glaucoma
☐ Inflammatory Disorder
☐ Keratoconus
☐ Floaters
☐ Eyestrain
☐ Age Related Macular Degeneration

☐ Cataract
☐ Nystagmus
☐ Injury
☐ Light Sensitivity
☐ Double Vision

☐ Surgery
☐ Strabismus
☐ Dry Eye
☐ Iritis/ Uveitis
☐ Night Vision Difficulty
☐ Retinal Degeneration/ Hole/ Detachment

☐ Patching
☐ Amblyopia
☐ Flashes
☐Itchy/ Gritty

☐Other: ____

Family History

Medical
☐High Blood Pressure
☐Diabetes
☐Cancer
☐Thyroid
☐Other: ____________________

Ocular
☐Glaucoma
☐Cataract
☐Surgery
☐Patching
☐Strabismus
☐Amblyopia
☐Nystagmus

☐Age-Related Macular Degeneration
☐Inflammatory Disorder
☐Retinal Degeneration/Hole/Detachment
☐Keratoconus
☐Corneal Disorders
☐Dry Eye
☐Other: ___________________________