# Welcome to Our Office!

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HAUG OPTOMETRY

So that we may know you better, please take a moment to fill out this information about yourself and your history.

Name:_____ M F Date:_____

Street Address:_____City:_____ Zip:_____

Home Phone: _____ Work Phone:_____ Birthdate:_____ Age:_____

Cell Phone: _____ Occupation: _____

E-Mail Address:_____ Employer: _____

Medical Insurance: _____

Eyecare Insurance: _____

Social Security #_____

**Whom may we thank for referring you?_____**

Please list your interests and hobbies:

**In the last few years have you experienced:**

- ❍ Blurry vision
- ❍ Flashes of Light
- ❍ Sunlight sensitivity
- ❍ Burning
- ❍ Floaters/ Spots
- ❍ Excessive tearing
- ❍ Crossing eyes
- ❍ Eye discomfort
- ❍ Trouble seeing at night
- ❍ Double vision
- ❍ Headaches
- ❍ Uncomfortable glasses
- ❍ Dryness
- ❍ Itchiness

**Date of last eye exam _____**

By whom? _____

**Do you currently wear Contact Lenses?** Yes No

What type of Contact Lenses? _____

Are you interested in changing your eye color? Yes No

What type of Contact solution used? _____

**If you wear contact lenses, are you satisfied with your vision and comfort?** Yes No

**Name of Family Physician _____**

Physician's Phone Number_____

Date of Last Physical Check-Up _____

**Do you ..... (Check if your answer is YES)**

- ❍ ...Work at a computer? _____hours/week
- ❍ ...Think you would benefit from lighter/thinner lenses?
- ❍ ...Have interest in the latest Contact Lens Design?
- ❍ ...Spend time outdoors? _____ hours/week
- ❍ ...Have prescription sunglasses?
- ❍ ...Prefer not to wear your glasses at times?
- ❍ ...Want more information on Laser Vision Correction?
- ❍ ...Have more than 1 pair of current RX glasses?
- ❍ ...Smoke? ❍...Use recreational drugs including marijuana?
- ❍ ...Drink more than 2 alcoholic beverages per day?
- ❍ ...Have family members in need of eyecare?

**FAMILY HISTORY**

Is there any family history of the following: (list relation to you please)

Blindness _____

Cataracts _____

Crossed Eyes _____

Glaucoma _____

Lazy Eye _____

Macular Degeneration _____

Retinal Problems _____

Cancer _____

Diabetes _____

Heart Disease _____

High Blood Pressure _____

Kidney Disease _____

Thyroid Disease _____

Other _____

**PERSONAL EYE HISTORY**

Have you ever been diagnosed or treated for:

- ❍ Cataracts
- ❍ Iritis/Uveitis
- ❍ Strabismus/Eye turn
- ❍ Corneal Abrasion
- ❍ Eye Injuries
- ❍ Other Eye Disorders?
- ❍ Eye Infections
- ❍ Macular Degeneration
- ❍ Retinal Detachment
- ❍ Glaucoma

**SURGICAL HISTORY**

Please list your major injuries, surgeries, and hospitalizations

***Please Turn this Form Over and Complete Side Two***

## REVIEW OF SYSTEMS

Have you had current or chronic problems in the following areas:

| SYSTEM | NO | YES | ? |
|---|---|---|---|
| CONSTITUTIONAL | | | |
| High Fever, Large Weight Loss/Gain | ❍ | ❍ | ❍ |
| DERMATOLOGIC (SKIN) | ❍ | ❍ | ❍ |
| NEUROLOGICAL | | | |
| Headaches | ❍ | ❍ | ❍ |
| Migranes | ❍ | ❍ | ❍ |
| Seizures | ❍ | ❍ | ❍ |
| ENDOCRINE | | | |
| Thyroid/Other Glands | ❍ | ❍ | ❍ |
| EARS, NOSE, MOUTH, THROAT | | | |
| Allergies/Hay Fever | ❍ | ❍ | ❍ |
| Sinus Congestion | ❍ | ❍ | ❍ |
| Runny Nose | ❍ | ❍ | ❍ |
| Post-Nasal Drip | ❍ | ❍ | ❍ |
| Chronic Cough | ❍ | ❍ | ❍ |
| Dry Throat/Mouth | ❍ | ❍ | ❍ |
| RESPIRATORY | | | |
| Asthma | ❍ | ❍ | ❍ |
| Chronic Bronchitis | ❍ | ❍ | ❍ |
| Emphysema | ❍ | ❍ | ❍ |
| VASCULAR/CARDIOVASCULAR | | | |
| Diabetes | ❍ | ❍ | ❍ |
| High Cholesterol | ❍ | ❍ | ❍ |
| Heart Pain | ❍ | ❍ | ❍ |
| High Blood Pressure | ❍ | ❍ | ❍ |
| Vascular Disease | ❍ | ❍ | ❍ |
| GASTROINTESTINAL | | | |
| Diarrhea | ❍ | ❍ | ❍ |
| Constipation | ❍ | ❍ | ❍ |
| Crohn's/Diverticulitis | ❍ | ❍ | ❍ |
| GENITOURINARY | | | |
| STD's/Kidney/Bladder | ❍ | ❍ | ❍ |
| BONES/JOINTS/MUSCLES | | | |
| Rheumatoid Arthritis | ❍ | ❍ | ❍ |
| Osteo Arthritis | ❍ | ❍ | ❍ |
| Muscle/Joint Pain | ❍ | ❍ | ❍ |
| LYMPHATIC/HEMATOLOGIC | | | |
| Anemia | ❍ | ❍ | ❍ |
| Bleeding Problems | ❍ | ❍ | ❍ |
| ALLERGIC/IMMUNOLOGIC/INFECT. | | | |
| Multiple Sclerosis | ❍ | ❍ | ❍ |
| Lupus | ❍ | ❍ | ❍ |
| Sarcoid | ❍ | ❍ | ❍ |
| Sjogren's | ❍ | ❍ | ❍ |
| Cold Sores | ❍ | ❍ | ❍ |
| PSYCHIATRIC | ❍ | ❍ | ❍ |

**IF YOU ANSWER YES TO THE SYSTEM QUESTIONS,**
or have a condition not listed, please explain and list:

**Current Medications**

Rx and over the counter: List names of medications including eye drops, vitamins and birth control pills.

**Allergies to Medications?** Yes No

Patient Signature

Doctor's Signature

Date