

Herman Advanced Family Eye Care

1111 15th Ave
Bloomer, WI 54724

510 Second Street
Chetek, WI 54728

Date: ____/____/____

General Information

Last Name _____	First Name _____	MI _____	BirthDay: ____/____/____
M or F _____	Parent / Legal Gaurdian / Spouse _____		
Address: _____	City: _____	State: _____	Zip: _____
Home Ph:() _____	Work Ph:() _____	Cell Ph:() _____	
Employer/School: _____	Occupation/School Grade: _____		
Email Address: _____	Sports/Hobbies: _____		
Emergency Contact: _____	Relation: _____	Phone: () _____	

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam: ____/____/____ Primary Physician/Clinic: _____

Date of Last Eye Exam: ____/____/____ Clinic/Eye Doctor's Name: _____

Do you wear glasses? Yes No All the time Occasionally Office Work Reading only Driving only

Do you wear contacts? Yes No Type: _____ How often do you replace them?: _____

Have you ever had eye injuries? Yes No Which Eye? _____

Have you ever had eye surgeries? Yes No Why? _____

Have you taken eye medication? Yes No Why? _____

Are you currently Pregnant or Nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed? _____

Glaucoma: Yes/No When were you diagnosed? _____

Macular Degeneration: Yes/No When were you diagnosed? _____

Please circle and explain any of the following past or present conditions that apply:

Blurred Vision - Distance	Burning Eyes	Floaters or Spots	Headaches
Blurred Vision - Near	Itchy Eyes	See Flashes	Migraine Headaches
Double Vision	Dry Eyes	See Halos	Loss of Vision
Eye Strain	Red Eyes	Poor Night Vision	Crossed Eyes
Eye Infections	Watery Eyes	Poor Color Vision	Light Sensitive

Notes:

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THE FOLLOWING CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: ___ None ___ High Blood Pressure ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	Endocrine: ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	Respiratory: ___ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: ___ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	Genitourinary: ___ None ___ Kidney Disease ___ Urinary Tract Infection ___ STD - Herpetic/Chlamydia ___ Other:	Psychiatric: ___ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: ___ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	Musculoskeletal: ___ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	Immunologic: ___ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: ___ None ___ Anemia ___ Leukemia ___ Other:	Gastrointestinal: ___ None ___ Crohn's ___ Colitis ___ Other:	Ear/Nose/Throat: ___ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: ___ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	Allergies (please list) ___ None Drug: Environmental:	Alcohol Use: Y N Amount: Tobacco Use: Y N Amount:

Please list physical reaction(s) to above allergies: _____

Please list any medications you are taking (including herbal):

_____ For _____	_____ For _____
_____ For _____	_____ For _____
_____ For _____	_____ For _____
_____ For _____	_____ For _____
_____ For _____	_____ For _____

Family History: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with the following DISEASE / CONDITION

High Blood Pressure	Yes/No	_____	Blindness	Yes/No	_____
Diabetes	Yes/No	_____	Cataracts	Yes/No	_____
Cancer	Yes/No	_____	Glaucoma	Yes/No	_____
Heart Disease	Yes/No	_____	Crossed Eyes	Yes/No	_____
Thyroid disease	Yes/No	_____	Macular Degeneration	Yes/No	_____
Lupus	Yes/No	_____	Retinal Detachment	Yes/No	_____

Reviewed by:

Dr _____

Date _____

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