

# Dressler Ophthalmology Associates, PLC

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Preferred form of address:  Mr.  Mrs.  Ms.  Miss  Dr.  first name

Marital Status:  married  single  divorced  widowed  minor Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Emergency Contact / relationship: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Occupation: \_\_\_\_\_ Do you work days, nights, both? \_\_\_\_\_

Have you experienced "glare" at night and/or when driving? \_\_\_\_\_

Have you noticed eyestrain or other problems during/after computer use? Describe: \_\_\_\_\_

What sports do you participate in? \_\_\_\_\_

What are your leisure/hobby/volunteer activities? \_\_\_\_\_

Are you interested in being fit for contacts today? \_\_\_\_\_

Are you interested in Laser Vision Correction? \_\_\_\_\_

If you presently wear glasses, what type(s) do you have? (Check all that you own)

(Please provide your present glasses for measurement)

- Non-prescriptive, over the counter reading glasses
- Prescriptive distance glasses
- Prescriptive reading glasses
- Prescriptive progressive/multifocal glasses (without a line)
- Prescriptive regular bifocals with a line/button or crescent insert
- Prescriptive regular trifocals with lines
- Prescriptive sunglasses of any type
- Sports or safety glasses of any type

Do you want a new eyeglass prescription so that you can buy new glasses/lenses? \_\_\_\_\_

If you presently wear contacts, what type do you have?

- Disposable softs (daily, weekly, monthly, quarterly)
- Disposable astigmatic (toric) softs (weekly, monthly, quarterly)
- soft bifocals (disposable, non-disposable)
- rigid gas permeables (regular, not bifocals)
- Non-disposable regular softs
- Non-disposable astigmatic softs
- Non disposable extended wear soft
- rigid gas permeables - bifocals

Provide us with your contact lens specifications and brand type, if known:

Right: \_\_\_\_\_ Left: \_\_\_\_\_

How old is your present pair of contact lenses? \_\_\_\_\_

Do you need your contact lens prescription duplicated or updated? \_\_\_\_\_

What method do you use to disinfect your contacts? \_\_\_\_\_

Do you sleep in your contacts ever? \_\_\_\_\_

Have you ever had any contact lens or solution problems? \_\_\_\_\_

Please let us know how you found out about this practice:

- Bell Atlantic Yellow Pages
- One Book Yellow Pages
- Referral Service
- Internet (dresslerlasereye.com)
- PPO or HMO Provider List
- Physician \_\_\_\_\_
- Another Patient \_\_\_\_\_

**Medical History Questionnaire**

*(Notice to Medicare patients: Medicare does not pay for routine eye exams, refractions for eyeglasses or screenings. If you have a medical problem, Medicare will pay for this.)*

**What problems are you currently having with your eye(s) (Right, Left or Both)? Indicate all that apply:**

- |                             |                              |                                  |
|-----------------------------|------------------------------|----------------------------------|
| _____ blurry vision         | _____ ache/strain/hurt       | _____ pink/red eyeball           |
| _____ glare/haloes          | _____ pain/pressure/headache | _____ pink/red eyelid            |
| _____ floaters/spots        | _____ sensitive to light     | _____ eyelash loss               |
| _____ flashing lights       | _____ burning/gritty/sandy   | _____ cysts/sties of lid         |
| _____ distortion/waviness   | _____ tearing, itching       | _____ drooping lid               |
| _____ other visual problems | _____ other discomforts      | _____ other eyeball/lid problems |

**Please provide specific details (timing, duration, frequency, quality, severity, associations):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you ever been treated for any eye problems in the past?** (e.g. cataracts, glaucoma, retina problems, eye injuries or surgeries, infections, inflammations, crossed or lazy eyes, etc.)  NO  YES, explain:

\_\_\_\_\_  
\_\_\_\_\_

**Have you ever been treated for any medical conditions?** (e.g. diabetes, high blood pressure, heart disease, asthma, etc.)?  NO  YES, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**List any anesthetic reactions or major operations/hospitalizations:**

\_\_\_\_\_  
\_\_\_\_\_

**Medications** - include by mouth, eyedrops, inhalers, skin meds (over-the-counter and prescriptive), vitamins, aspirin, etc.: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Medication Allergies:**  NO  YES List: \_\_\_\_\_

**If applicable, are you pregnant?**  NO  YES

**Have you ever smoked?**  NO  YES: Presently smoke (how much \_\_\_\_\_ )  
 Quit Smoking / When \_\_\_\_\_

**Do you drink alcohol?**  NO  YES, explain how much: \_\_\_\_\_

<b>Have you ever been exposed to or infected with:</b>	YES	NO	If Yes, explain
Occupational lasers, x-rays or chemicals?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Do you drive?**  NO  YES  Daytime Only  Anytime

**Have you ever had any of the following problems?**

	YES	NO	If Yes, explain
Chronic fever, weight change, fatigue, sweats, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat - e.g. sinus, allergies, hearing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart/Vascular - e.g. chest pains, leg cramps, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breathing Problems - e.g. bronchitis, wheezing, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal - e.g. abdominal pain, diarrhea, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems - e.g. kidney, prostate, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin - e.g. rash, eczema, rosacea, cancers, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal - e.g. arthritis, swollen joints, muscle ache, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neuroskeletal - e.g. numbness, weakness, spinning, headaches, head injuries, speech/memory, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric - e.g. depression, anxiety, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Endocrine - e.g. thyroid, pituitary, diabetes, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood - e.g. bruising/bleeding easily, anemia, etc.	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Do any medical or eye diseases run in your family** (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration, retinal diseases/detachments, blindness, wandering/crossed eyes, lazy eye, corneal diseases, etc.)?  NO  YES, explain: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Reviewed by physician      Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician signature:** \_\_\_\_\_

**Updated Date**

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