



**PRIMARY EYE CARE CENTERS**  
Treatment & Management of Ocular Disease

**GENERAL EXAM FORM**

State Street       Edgebrook       Crystal Lake       Brookside

Patient Number: \_\_\_\_\_

Exam date: \_\_\_\_/\_\_\_\_/\_\_\_\_

PATIENT: \_\_\_\_\_ Birthday: \_\_\_\_/\_\_\_\_/\_\_\_\_

Occupation: \_\_\_\_\_ RACE: \_\_\_\_\_

Reason for today's visit? \_\_\_\_\_ GENDER: MALE/ FEMALE

Are you interested in contacts and want the additional contact exam today? YES / NO

Date of Last Eye Exam: \_\_\_\_\_ Where/Whom? \_\_\_\_\_

Who is your Primary Care Physician? \_\_\_\_\_

Where is his/her Office? \_\_\_\_\_

When was your last general medical examination? \_\_\_\_\_

Review of Systems: Pertinent( 1 Reviewed)      Extended (2-9)      Complete (>10)      PFSH: Complete (2or 3)

**Medical History: Please Check (ROS)**

Do you have (check all that apply):	Does An Immediate Family Member Have:
( ) Diabetes ( ) Insulin ( ) Multiple Sclerosis	( ) Diabetes ( ) Insulin ( ) Multiple Sclerosis
( ) Thyroid dysfunction ( ) Epilepsy	( ) Thyroid dysfunction ( ) Epilepsy
( ) Heart disease ( ) Depression	( ) Heart disease ( ) Depression
( ) High Blood Pressure ( ) Panic Disorder	( ) High Blood Pressure ( ) Panic Disorder
( ) Lupus ( ) Schizophrenia	( ) Lupus ( ) Schizophrenia
( ) Rheumatoid Arthritis ( ) Asthma	( ) Rheumatoid Arthritis ( ) Asthma
( ) Crohn's ( ) Bronchitis	( ) Crohn's ( ) Bronchitis
( ) Colitis ( ) Emphysema	( ) Colitis ( ) Emphysema
( ) Ulcer ( ) Cigarette Smoker	( ) Ulcer ( ) Cigarette Smoker
( ) Anemia ( ) Upper Resp. Infect	( ) Anemia ( ) Upper Resp. Infect
( ) Leukemia ( ) Glaucoma	( ) Leukemia ( ) Glaucoma
( ) Eczema ( ) Cataracts	( ) Eczema ( ) Cataracts
( ) Rosacea ( ) Blindness	( ) Rosacea ( ) Blindness
( ) Psoriasis ( ) Macular Degeneration	( ) Psoriasis ( ) Macular Degeneration
( ) Fibromyalgia ( ) Osteoarthritis	( ) Fibromyalgia ( ) Other _____
( ) Muscular Dystrophy ( ) Other _____	( ) Muscular Dystrophy
Allergies yes / no List: _____	( ) Osteoarthritis _____
Drug Allergies: LIST: _____	Allergies: NONE / List: _____

Do you take any medication prescribed by a doctor? Y / N      Over the counter? Y / N

Please List: \_\_\_\_\_

**Current Eye Related Questions: Please Circle yes or no**

Y / N Do you use a computer? \_\_\_\_\_ If so, how many hours per day? \_\_\_\_\_

Y / N Do you have frequent headaches? Explain \_\_\_\_\_

Y / N Do you wear eyeglasses? How old are they? \_\_\_\_\_

How do you rate your vision with your present prescription? Good \_\_\_ Fair \_\_\_ Poor \_\_\_

Y / N Have you ever worn contact lenses in the past? \_\_\_\_\_

Y / N Do you now wear contact lenses? How old are they? \_\_\_\_\_

What type of contact lens? \_\_\_\_\_ How many hours a day do you wear them? \_\_\_\_\_

Y / N Do you have problems with night vision? \_\_\_\_\_

Y / N Do you ever see double? When? \_\_\_\_\_

Y / N Do you have problems with color vision? \_\_\_\_\_

Y / N Do sunlight or bright lights bother you? \_\_\_\_\_

**For Office Use**

NOTES: \_\_\_\_\_

**ROS:**

Primary ROS taken today

Reviewed \_\_\_\_/\_\_\_\_/\_\_\_\_

W/ changes noted on form

INITIALS: \_\_\_\_\_