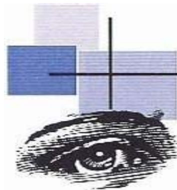

PRIMARY EYE CARE CENTERS

Treatment & Management of Ocular Disease

GENERAL EXAM FORM

☐ Rockford ☐ Crystal Lake

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
( ) Rheumatiod Arthritis	( ) Asthma	( ) Rheumatiod 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: