ST. CROIX VISION CENTER AND OPTICAL
WELCOME FORM

Welcome to St. Croix Vision Center and Optical. Thank you for choosing us for your eye care needs. Please take a moment to complete the following information.

Name: ____ Date: ________________

Occupation: ___________________________________ Employer: ___________________________________

Review of Systems

If Yes, please indicate specific condition

Eyes (Glaucoma, Cataract, Lazy Eye, Retina Problems, Headaches, Dryness, Itching, Infections, Double Vision, Floaters, Loss of Vision, Other): ____________________________________ O Yes O No

Constitution (Cancer, Fatigue Syndrome, Other): ____________________________________ O Yes O No

Ear/Nose/Throat (Hearing Loss, Sinusitis, Dry Mouth, Laryngitis): ________________________ O Yes O No

Neurological (Multiple Sclerosis, Epilepsy, Tumor, Stroke/CVA, Migraine, Other): O Yes O No

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Psychiatric (Depression, Anxiety, Bipolar Disorder, Other): ___________________________ O Yes O No

Cardiovascular (High Blood Pressure, Heart Disease, Congestive Heart Failure, Other): O Yes O No

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Respiratory (Asthma, Bronchitis, Sleep Apnea, Other): _______________________________ O Yes O No

Gastrointestinal (Crohn's, Colitis, Acid Reflux, Other): _______________________________ O Yes O No

Genitourinary (Kidney Disease, Prostate Disease, Other): ______________________________ O Yes O No

Musculoskeletal (Arthritis, Fibromyalgia, Ankylosing Spondylitis, Other): ________________ O Yes O No

Integumentary (Eczema, Rosacea, Psoriasis, Shingles, Other): __________________________ O Yes O No

Endocrine (Type 1 or Type 2 Diabetes, Thyroid Dysfunction, Other): ____________________ O Yes O No

Lymphatic (Anemia, Leukemia, Other): ____ O Yes O No

Immune/Allergy (Rheumatoid Arthritis, Lupus, Sjogren's, Environmental Allergies): O Yes O No

____

Medication Allergies? (Please list names): O Yes O No

____

List of Current Medications (including eye drops):

____

____

Primary care physician/clinic name: ______________________________

Reason for eye exam today: ______________________________

Date of last eye exam: ____________________ Pregnant/Nursing: O Yes O No

Family History

Family Medical History - If yes, please indicate relationship to patient (only immediate family members)

High Blood Pressure:	O Yes	O No	Relationship: ____________
Diabetes:	O Yes	O No	Relationship: ____________
Cancer:	O Yes	O No	Relationship: ____________
Thyroid:	O Yes	O No	Relationship: ____________
Other: ____________			Relationship: ____________

Family Ocular History - If yes, please indicate relationship to patient (only immediate family members)

Glaucoma:	O Yes	O No	Relationship: ____________
Retinal Detachment:	O Yes	O No	Relationship: ____________
Cataracts:	O Yes	O No	Relationship: ____________
Macular Degeneration:	O Yes	O No	Relationship: ____________
Blindness:	O Yes	O No	Relationship: ____________
Lazy Eye:	O Yes	O No	Relationship: ____________

Social History

Do you use nutritional supplements (vitamins, etc.)? O Yes O No

Do you drink alcohol? O No O Occasional O 1/day O 2-3/day O 4+/day

Do you use tobacco products? O No O Occasional O 1/2 pack/day O 1 pack/day O 1+ pack/day

Please list any hobbies/interests: ______________________________

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Glasses/Contact Lens History

Do you currently wear glasses? O Yes O No O Full time O Part time

Type of glasses? O Single Vision O Bifocal O Trifocal O Progressive (no line bifocal)

Do you wear contact lenses? O Yes O No

If no, are you interested in trying them? O Yes O No

Brand of contact lenses? ______________________________

Today's wearing time? ______________________________

What contact lens solution do you use? ______________________________