

Sharper Vision Eyecare P.C.
Dr Gail Schechter Dr. Terri Gieske

Name _____ DOB ____ / ____ / ____ Age ____ Gender M F Date ____ / ____ / ____

Address _____ City _____ State _____ Zip _____

Emergency Contact/Number _____ SS# _____

Home Phone _____ Work Phone _____ Cell Phone _____

Vision Insurance _____ Health Insurance _____

Primary Card Holder of Insurance _____ DOB ____ / ____ / ____

Last Eye Exam/Eye Dr. _____ Drug Allergies to _____

Current Meds _____

Referred by: _____

Email Address _____ Would you prefer to be contacted by email? Yes/No

Past History*

Have you ever been diagnosed with eye problems? Cataract: Yes/No Macular Degeneration Yes / No Glaucoma: Yes/No
Other eye problems? _____

Have you ever had any surgery? Yes/No If yes, please explain _____

Has anyone in your family ever been diagnosed with: Cataract Yes/No Glaucoma: Yes/No Macular Degeneration: Yes/No
Other eye conditions _____

Has anyone in your family been treated for: High Blood Pressure: Yes/No Diabetes: Yes/No Other _____

Social History*

Occupation _____ Average # of hours of computer use per day _____

Do you smoke? Yes/No Do you drink alcohol daily? Yes/No Diabetes: Yes/No Other _____

Do you have special visual needs at work, home, or for hobbies? Explain if yes _____

Code History () New Pertinent (1 – 2 areas) () New Complete (3 areas) () Est. Pertinent (1 area) () Est. Complete (2-3 areas)

Patient / Guardian Signature _____ **Date** _____

Patient / Guardian Signature _____ **Date** _____

Patient / Guardian Signature _____ **Date** _____

Dr. Signature _____ **Date** _____

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Review of Systems*

- Constitutional** None _____
- Headaches/Migraines
 - Weight loss
 - Fever
 - Fatigue
 - Trauma
 - Cancer
 - Arthritis
 - Currently Pregnant
 - Other /Meds _____

- Genitourinary** None _____
- Urinary tract infections
 - Kidney problems
 - STD
 - Other/Meds _____

- Hematologic/Lymphatic** None _____
- Anemia
 - Leukemia
 - Clotting Disorder
 - Other/Meds _____

- Musculoskeletal** None _____
- Fibromyalgia
 - Osteoarthritis
 - Muscular Dystrophy
 - Other/Meds _____

- Allergic/Immunologic** None _____
- Drug Allergy to:
 - Hay Fever
 - Lupus
 - Other/Meds _____

- Skin/Integumentary** None _____
- Eczema
 - Skin cancer
 - Psoriasis
 - Other/Meds _____

- Ears, Nose, Throat** None _____
- Hearing Problems
 - Upper Respiratory Tract Infection
 - Other/Meds _____

- Eyes** None _____
- Dry Eyes
 - Floaters
 - Flashes
 - Pink or Red Eye
 - Eye Strain
 - Light Sensitivity
 - Night Blindness
 - Double Vision
 - Itching eyes
 - Excessive Tearing
 - Other _____

- Cardiovascular** None _____
- Heart Disease
 - Hypertension
 - Stroke
 - Vascular disease
 - Other/Meds _____

- Neurological** None _____
- Multiple Sclerosis
 - Epilepsy
 - Other/Meds _____

- Psychiatric** None _____
- Depression
 - Panic Disorder
 - Schizophrenia
 - Other/Meds _____

- Respiratory** None _____
- Asthma
 - Bronchitis
 - Emphysema
 - Other/Meds _____

- Endocrine** None _____
- Diabetes
 - Thyroid Problems
 - Hormonal Problems
 - Other/Meds _____

- Gastrointestinal** None _____
- Ulcer
 - Colitis
 - Digestive disorder
 - Other/Meds _____

Office use only below:
 1- () Problem pertinent 2-9 () Extended 10-14 () Complete

Patient / Guardian Signature _____ **Date** _____

Patient / Guardian Signature _____ **Date** _____

Patient / Guardian Signature _____ **Date** _____

Dr. Signature _____ **Date** _____

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Dilation Refusal

I do not want my eyes dilated. I understand that the doctor feels that it is necessary for a complete eye examination. I elect to omit this procedure and will not hold Drs. Gieske and/or Schechter responsible for any complications that may occur by the lack of this procedure. Dilation helps detect optic nerve disease, retinal pathology and brain dysfunction

Patient / Guardian Signature _____ Date _____

Contact Lens Patients:

Do You Sleep In Contacts? Yes No If Yes, How Often? _____

How Often Do You Replace Your Lenses? _____

Type of Contact Lenses? _____

Vision With Contacts: Great Good Poor

Comfort Of Lenses: Great Good Poor

How Many Hours Per Day Do You Wear Your Lenses? _____

What Solution(s) Do You Use? _____

When Did You Last Wear Your Contact Lenses? _____

Are You Interested In Colored Contact Lenses? Yes No

Patient/Guardian Signature _____ Date _____

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