visualsense EYECARE
Optometry & Vision Therapy

OFFICE USE ONLY:
RET PHOTO TAKEN [ ]
TAKE RET PHOTO WHEN DILATED [ ]
NO RETINAL PHOTO [ ]
SCANNED [ ]

EXAMINATION INTAKE FORM – ADULT

PLEASE PRINT CLEARLY

FULL NAME:	BIRTH DATE (DD/MM/YY):
HOME ADDRESS:	HEALTH CARD #:
CITY:	SPOUSE NAME:
POSTAL CODE:	CELL PHONE #:
HOME PHONE #:	ALTERNATE #:
EMAIL ADDRESS:	OCCUPATION:

[ ] I GIVE [ ]I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSION TO EMAIL ME WITH MEDICAL REPORTS, EDUCATION, PERSONAL COMMUNICATIONS & PROMOTIONS

[ ] I GIVE [ ]I DO NOT GIVE VISUAL SENSE EYE CARE PERMISSIN TO CALL AND LEAVE A MESSAGE AT HOME REGARDING YOUR CARE AT OUR PRACTICE

SIGNATURE OF CONSENT:	DATE OF CONSENT:
HOW WERE YOU REFERRED TO US?	REASON FOR REFERRAL:

HEALTH HISTORY

FAMILY DOCTOR:	DATE OF LAST EYE EXAM:
ALLERGIES (please specify):	HOSPITALIZATIONS:
MEDICATIONS:	REASONS FOR MEDICATIONS:

ANY HISTORY OF: (IF A FAMILY MEMBER HAS ANY MEDICAL HISTORY, PLEASE INDICATE WHO [grandmother, father, etc])

[ ] SELF [ ] FAMILY	ENVIRONMENTAL ALLERGIES	**[ ] SELF [ ] FAMILY**	HIGH BLOOD PRESSURE
[ ] SELF [ ] FAMILY	HEART DISEASE	**[ ] SELF [ ] FAMILY**	CATARACTS
[ ] SELF [ ] FAMILY	ARTHRITIS	**[ ] SELF [ ] FAMILY**	GLAUCOMA
[ ] SELF [ ] FAMILY	HIGH CHOLESTEROL	**[ ] SELF [ ] FAMILY**	STROKE
[ ] SELF [ ] FAMILY	MACULAR DEGENERATION	**[ ] SELF [ ] FAMILY**	RETINAL DETACHMENT
[ ] SELF [ ] FAMILY	EYE INJURY	**[ ] SELF [ ] FAMILY**	TUBERCULOSIS
[ ] SELF [ ] FAMILY	DIABETES	**[ ] SELF [ ] FAMILY**	HIV/ HEPATITIS
[ ] SELF [ ] FAMILY	EYE SURGERY	**[ ] SELF [ ] FAMILY**	NEUROMUSCULAR

VISUAL HISTORY & EYE HEALTH

[ ] BLURRED DISTANCE VISION / SQUINTING	[ ] UNCOMFORTABLE CONTACT LENSES
[ ] BLURRED INTERMEDIATE VISION	[ ] AMBLYOPIA (LAZY EYE)
[ ] BLURRED CLOSE VISION	[ ] DROOPING EYELID
[ ] SUDDEN VISION LOSS	[ ] FLUCTUATING VISION
[ ] DOUBLE VISION	[ ] GLARE/ LIGHT SENSITIVITY
[ ] FLOATING SPOTS	[ ] MUCUS DISCHARGE
[ ] RED EYES	[ ] STRABISMUS
[ ] WATERY EYES/ BURNING EYES	[ ] CORNEAL TRANSPLANT
[ ] FREQUENT HEADACHES	[ ] EYE TURN
[ ] FLASHES OF LIGHT	[ ] KERATOCONUS
[ ] DRY EYES	[ ] OTHER:
HISTORY OF CONCUSSION: **[ ] YES [ ] NO**	DATE OF LAST CONCUSSION (MM/DD/YY):

PARTICIPANT OF COMPETITIVE SPORT : **[ ] YES [ ] NO**	HOBBIES:	**SEE BACK ->**

SEE BACK ->

CONTACT LENS WEARERS	
IS THERE EVER A TIME YOU WISH YOU DID NOT HAVE TO WEAR GLASSES? **[ ] YES [ ] NO**	
DO YOU CURRENTLY WEAR CONTACT LENSES? **[ ] YES [ ] NO**	IF YES, WHEN?
HOW OFTEN DO YOU THROW THEM OUT?	HOW MANY HOURS PER DAY?
WHAT KIND OF LENSES? **[ ]** SOFT DISPOSABLE **[ ]** SOFT NON-DISPOSABLE **[ ]** RIGID GAS PERMEABLE **[ ]** HYBRID LENS **[ ]** SCLERAL LENS	