

ABOUT YOU

Full Name: Mr. Mrs. Miss. Ms. Dr. Prof. _____ Gender M F

Nickname: _____ DOB ____ / ____ / ____ Phone Number: _____

Email Address: _____ Primary Address: _____

Approx. Height & Weight ____ ft ____ in ____ lbs

American Indian/Alaskan Native	Do you use tobacco products?	Y \longrightarrow	Type _____
African American		N	Frequency _____
Asian		Not anymore	
Caucasian	Do you drink alcohol ?	Y \longrightarrow	Minimal
Hispanic or Latino		N	Moderate
Native Hawaiian/Pacific Islander		Not anymore	Excessive
Other			
Decline			

How did you hear about us? _____

WORK/HOBBIES

Occupation _____

Employer _____

Hours spent on computer per day:

0-3	6-9
3-6	9+

Special visual demands for work:

Computer Lenses
Safety Glasses
Extra magnification
Other _____



Reading/
Writing



Golf



Swimming



Cycling



Fishing/
Boating



Travel



Knitting/
Sewing



Motorcycles

VISION

Are you happy with your vision?	Y N \longrightarrow	Please mark any symptoms you are experiencing:
Do you currently/are you supposed to wear glasses ?		Blurred Vision
Would you like to get new glasses this year?		Night Glare
Have you worn contacts before?		Eyestrain
Are you interested in contacts this year?		Eye Pain
Are you interested in laser vision correction ?		Light Sensitivity
Are you interested in eliminating the need for glasses or contact lenses non-surgically ?		Headache
		Poor Night Vision
		Double Vision
		Loss of Side Vision
		Floater
		Flashes of Light
		Total Loss of Vision
		Other _____

EYE HEALTH

When was your last **eye exam**? _____ Doctor _____

When was your last **physical**? _____ Doctor _____

Please mark if you have ever been diagnosed with:

Cataract	Glaucoma	Macular Degeneration
Diabetic Retinopathy	Iritis or Uveitis	Nevus (Freckle) of the Eye
Dry Eye	Keratoconus/Other Corneal Disorder	Retinal Defects or Degenerations
Eye Infection/Inflammation/Allergy		

Do you have any history of eye disease, injuries, or surgeries not listed above? If so, please list:



OVERALL HEALTH:

- No Health Problems
- Developmental Delays
- Cancer
- Fatigue Syndrome
- Other _____



EAR, NOSE AND THROAT:

- None
- Hearing Loss
- Sinusitis
- Dry Mouth
- Laryngitis
- Other _____



PSYCHIATRIC:

- None
- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder
- Other _____



CARDIOVASCULAR:

- None
- Hypertension
- Stroke/CVA
- Heart Disease
- Vascular Disease
- Congestive Heart Failure
- Other _____



HEMATOLOGIC/LYMPHATIC:

- None
- Anemia
- Large Volume Blood Loss
- Ulcer
- Hypercholesteremia
- Other _____



RESPIRATORY:

- None
- Cigarette Smoker
- Asthma
- Bronchitis
- Emphysema
- Chronic Obstruction
- Sleep Apnea
- Other _____



GASTROINTESTINAL:

- None
- Crohn's
- Colitis
- Ulcer
- Acid Reflex
- Celiac Disease
- Other _____



GENITOURINARY:

- None
- Kidney Disease
- Prostate Disease/Cancer
- STD-Herpetic/Chlamydia
- Benign Prostate Hypertrophy
- Pregnant _____ weeks
- Nursing
- Other _____



MUSCULOSKELETAL:

- None
- Arthritis
- Osteoarthritis
- Fibromyalgia
- Muscular Dystrophy
- Ankylosing Spondylitis
- Osteoporosis
- Gout
- Other _____



**INTEGUMENTARY
(body's outer layer):**

- None
- Eczema
- Rosacea
- Psoriasis
- HSV/Cold Sores
- Herpes Zoster/Shingles
- Other _____



ALLERGIC/IMMUNE:

- None
- Drug Allergies
- Environmental Allergies
- Rheumatoid Arthritis
- Lupus
- Sjögren's Syndrome
- Other _____



NEUROLOGICAL:

- None
- MS
- Epilepsy
- Cerebral Palsy
- Tumor
- Stroke/CVA
- Migraine
- Other _____



ENDOCRINE:

- None
- Type 1 Diabetes
- Type 2 Diabetes
- If diabetic, please list:
Last A1C: _____
- Average BSL: _____
- Thyroid Dysfunction
- Hormonal Dysfunction
- Other _____

Mark if family history is unknown. You may skip to the next page.

Please mark any that apply:

	Mother	Father	Sibling	Child	Grandparent	Unsure
Cancer						
Diabetes						
Hypertension						
Cataract						
Glaucoma						
Corneal Disease						
Macular Degeneration						
Retinal Detachment						

MEDICATIONS

For those on multiple medications, you are welcome to provide a list instead if you prefer.

Please list current medications: _____ And their purpose: _____

If you are taking any **eye vitamins**, please list: _____
 Preferred Pharmacy _____ Pharmacy Location _____
 Medication Allergies _____
 _____ Other Allergies _____

DRY EYE SCREENING

Please mark if you are experiencing any of the following **comfort issues**:

- | | | | |
|---------|----------|---------------------|--------------------|
| Redness | Itching | Soreness/Irritation | Dryness/Grittiness |
| Burning | Watering | Discharge | Pain |

Please rate the **frequency** of each symptom:

0= Never 1= Sometimes 2= Often 3= Constantly

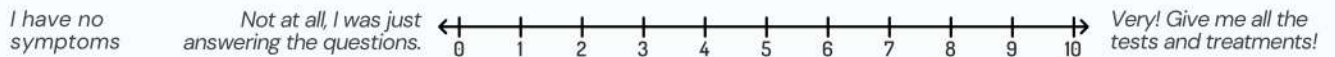
...and the **severity** of each symptom:


0= None 1= Tolerable 2= Uncomfortable 3= Bothersome 4= Intolerable

	0	1	2	3
Dry/Gritty/Scratchy				
Soreness/Irritation				
Burning/Watering				
Eye Fatigue				

	0	1	2	3	4

How motivated are you to pursue treatment for dry eye symptoms? (circle response)



Have you been using any eye drops? Yes  Name of drop: _____
 No How often do you use it? _____
 Used within last 4 hours? Yes No

FOR OFFICE USE ONLY

Tear Lab: OD _____ OS _____

Total SPEED dry eye score: _____ /28

