HANDEL VISION CLINIC
Advanced Eye Care You Can Trust

ABOUT YOU

Full Name ☐Mr. ☐Mrs. ☐Miss ☐Ms. ☐Dr. ☐Prof.

_____

Nickname _____ Gender ☐ ☐

DOB ____/____/____

Referred by _____

Preferred Language _____

Approx. Height & Weight ____ ft ____ in ____ lbs

Do you use tobacco products? ☐ Y → Type _____ ☐ N ☐ Not anymore Frequency _____

Do you drink alcohol? ☐ Y → ☐ Minimal ☐ Moderate ☐ Excessive ☐ N ☐ Not anymore

CONTACT

_____

_____

_____

_____

RACE

- ☐ American Indian/Alaskan Native
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Decline

HOBBIES

☐ Reading/ Writing ☐ Golf ☐ Swimming ☐ Cycling

☐ Fishing/ Boating ☐ Travel ☐ Knitting/ Sewing ☐ Motorcycles

Other _____

EYE HEALTH HISTORY

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

Doctor _____

When was your last **physical**? _____

Doctor _____

Please mark if you have ever been diagnosed with:

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

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

_____

_____

YOUR HEALTH

OVERALL HEALTH:

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

EAR, NOSE AND THROAT:

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

PSYCHIATRIC:

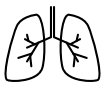
- [ ] None
- [ ] Depression
- [ ] Attention Deficit
- [ ] Anxiety Disorder
- [ ] Bipolar Disorder
- [ ] Other _____

CARDIOVASCULAR:

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

HEMATOLOGIC/LYMPHATIC:

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

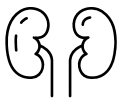


RESPIRATORY:

- [ ] None
- [ ] Cigarette Smooker
- [ ] 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 _____

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MEDICATIONS AND PHARMACY

Please list current medications:

And their purpose:

Preferred Pharmacy _____

Pharmacy Location _____

Medication Allergies _____

If you are currently using any **eye drops/vitamins**, please list:

Other Allergies _____

FAMILY HISTORY

☐ *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	☐	☐	☐	☐	☐	☐

Other: _____

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YOUR VISION

	Y	N
Are you happy with your vision?	☐	☐
Are you interested in **contacts**?	☐	☐
Are you interested in **laser vision correction?**	☐	☐
Are you interested in **eliminating** the need for glasses or contact lenses **non-surgically?**	☐	☐
Have you worn **contacts** before?	☐	☐
Do you currently wear glasses?	☐	☐

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

- ☐ Blurred Vision
- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Loss of Side Vision

Other _____

_____

Do you currently wear contacts? Y ☐ N ☐

GLASSES

How old are your glasses? _____

When do you wear your **glasses**?

- ☐ Full time
- ☐ For near only
- ☐ For distance only
- ☐ For computer use
- ☐ When not wearing contacts
- ☐ Other _____

Are you planning to get new glasses this year?

- ☐ Yes
- ☐ No
- ☐ Only if needed
- ☐ New lenses in current frame

CONTACT LENSES

Do you wear your contact lenses daily? Y ☐ N ☐

How often do you replace your lenses? _____

What type of lenses do you wear? _____

How many hours per day do you wear them? _____

What type of solution or drops do you use? _____

How often do you sleep in your lenses? _____

How old are your current lenses? _____

What is one thing you think could be better about your lenses?

_____

_____

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YOUR SYMPTOMS

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

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

WORK DEMANDS

Occupation _____

Employer _____

Hours spent on computer per day:

☐ 0-3 ☐ 3-6 ☐ 6-9 ☐ 9+

Special visual demands for work:

☐ Computer Lenses ☐ Safety Glasses
☐ Extra magnification ☐ Other _____

DRY EYE SCREENING

Rate the **severity** of each symptom:

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

	0	1	2	3	4
Dryness/Grittiness	☐	☐	☐	☐	☐
Soreness/Irritation	☐	☐	☐	☐	☐
Burning	☐	☐	☐	☐	☐
Watering	☐	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐	☐

Rate the **frequency** of each symptom:

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

	0	1	2	3
Dryness/Grittiness	☐	☐	☐	☐
Soreness/Irritation	☐	☐	☐	☐
Burning	☐	☐	☐	☐
Watering	☐	☐	☐	☐
Eye Fatigue	☐	☐	☐	☐

FOR OFFICE USE ONLY

Tear Lab: OD _____ OS _____

Total SPEED dry eye score: ____/28