



Name: _____

Date: _____

Please Provide the following: Height: _____ Weight: _____

Please List Any Medications You are Taking (You may supply a separate list if needed):

1. _____
2. _____
3. _____
4. _____

Please list Drug Allergies:

Primary Care Physician:

Are you Pregnant? ☐ Yes ☐ NoAre you Nursing? ☐ Yes ☐ No

Do you have problems with any of the following?:

- | | | |
|---------------------------------------|------------------------------|-----------------------------|
| Diabetes | ☐ Yes | ☐ No |
| Ear/Nose/Throat/Sinus | ☐ Yes | ☐ No |
| Digestive System | ☐ Yes | ☐ No |
| Blood/Lymph System | ☐ Yes | ☐ No |
| Endocrine (i.e. Thyroid) | ☐ Yes | ☐ No |
| Central/Nervous System | ☐ Yes | ☐ No |
| Mental/Emotional State | ☐ Yes | ☐ No |
| Cardiovascular (Heart/Blood Pressure) | ☐ Yes | ☐ No |

Musculoskeletal ☐ Yes ☐ NoRespiratory ☐ Yes ☐ NoGenitourinary ☐ Yes ☐ NoImmunologic ☐ Yes ☐ NoDo you smoke? ☐ Yes ☐ No

If yes, how many pack/day? _____

Do you drink alcohol? ☐ Yes ☐ No

If yes, how much and how often? _____

Do you:

Wear contact lenses? ☐ Yes ☐ No

If no...are you interested?*

See flashing lights? ☐ Yes ☐ NoHave dry, gritty eyes? ☐ Yes ☐ NoHave watery eyes? ☐ Yes ☐ NoHave problems with night driving and/or glare? ☐ Yes ☐ NoWork on a computer? ☐ Yes ☐ No

If yes, how many hours per day? _____

Have you had cataract surgery? ☐ Yes ☐ No

If yes...Date: (R) _____ (L) _____

Doctor: _____

Is there a family history of glaucoma, macular degeneration or diabetes? ☐ Yes ☐ No

Other Surgery: (Please list with dates)

Return visit reviews:

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

*Please be aware that a contact lens evaluation is not part of a regular exam and has an additional fee that may not be covered by insurance.
(please initial)

Encounter Form For Optometry

J Elliott



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