Primary EyeCare

Primary Eye Care-Delano
1045 Crossing Drive, Ste 200
Delano, MN 55328
763-777-9393
Fax: 763-777-9358

Primary EyeCare-Hutchinson
1059 Hwy 15 S.
Hutchinson, MN 55350
320-587-4744
Fax: 320-587-9168

Primary EyeCare-Litchfield
520 Hwy 12 E., Ste 106
Litchfield, MN 55355
320-693-9333
Fax: 320-593-0520

Date: ___/___/___

Last Name:_____First Name:_____Middle Initial:_____

☐M ☐F Occupation:_____
Employer:_____

Hobbies: ☐ Golf ☐ Boating/Fishing ☐ Biking/Motorcycle ☐ Tennis ☐ RunningGaming ☐ Shooting/Hunting ☐ Musical Instrument, Other_____

Last Eye Exam Date/Location:_____Primary Care Physician/Location_____

Do you have any of these problems currently below?	**Y**	**N**		**Y**	**N**
Eye pain or soreness	☐	☐	Do you wear Glasses?	☐	☐
Blurred Vision **without** Glasses/Contacts	☐	☐	If Yes, do you have a back up pair?	☐	☐
Blurred Vision **with** Glasses/Contacts	☐	☐	Do you currently wear Contact Lenses?	☐	☐
Flashes/Floaters in vision	☐	☐	If Yes, how would you rate comfort and vision, 1 poor 10 excellent?	#	
Distorted vision/halos	☐	☐			
Loss of side vision	☐	☐	If not wearing Contacts, any interest?	☐	☐
Double vision	☐	☐			
Dryness	☐	☐	How much time do you spend outdoors a day?	hrs	
Mucous discharge	☐	☐			
Redness	☐	☐	Do you have sunglasses?	☐	☐
Sandy or gritty feeling	☐	☐	If Yes, W/Prescription?	☐	☐
Itching	☐	☐			
Burning	☐	☐	Do you want info on Laser Vision Correction?	☐	☐
Foreign body sensation	☐	☐			
Excess tearing/watering	☐	☐	Do you want info on non-surgical option?	☐	☐
Glare/light sensitivity	☐	☐			
Tired eyes	☐	☐			
Crossed eyes, lazy eye	☐	☐			

Personal Medical History (Review of Systems): Please check any of the following APPLIES to you, and list any medications for each condition that you check. IF YOU HAVE NONE OF THESE CONDITIONS PLEASE CHECK NONE.

Cardiovascular: ☐ None ☐ Hypertension ☐ Cholesterol ☐ Stroke ☐ Heart Disease ☐ Other	**Endocrine:** ☐ None ☐ Non-Insulin Dependent Diabetes ☐ Insulin Dependent Diabetes ☐ Thyroid Problem ☐ Hormonal Dysfunction ☐ Other:	**Respiratory:** ☐ None ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other:
Constitutional: ☐ None ☐ Cancer ☐ Trauma/Large Volume Blood Loss ☐ Developmental Disability ☐ Other:	**Ocular:** ☐ None ☐ Glaucoma ☐ Macular Degeneration ☐ Detached Retina ☐ Other:	**Psychiatric:** ☐ None ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other:
Neurological: ☐ None ☐ Multiple Sclerosis ☐ Epilepsy ☐ Cerebral Palsy ☐ Tumor ☐ Other:	**Musculoskeletal:** ☐ None ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular Dystrophy ☐ Ankylosing Spondylitis ☐ Other:	**Immunologic:** ☐ None ☐ AIDS or HIV ☐ Rheumatoid Arthritis ☐ Lupus ☐ Other: ☐
Hematological: ☐ None ☐ Anemia ☐ Leukemia ☐ Other:	**Gastrointestinal:** ☐ None ☐ Crohn's ☐ Colitis ☐ Other:	**Ear/Nose/Throat:** ☐ None ☐ Hearing Loss ☐ Upper Respiratory Infection ☐ Other:
Dermotologic: ☐ None ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other:	**Allergies** (please list) ☐ None Drug: Environmental:	**Alcohol Use** ☐ Y ☐ N amount: **Tobacco Use** ☐ Y ☐ N amount:

Please list any Medications and/or Drugs that you are taking (including herbal): or See Attached List____

_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____
_____**For**_____ _____**For**_____

Women: Are you Pregnant or Nursing currently? Y or N

Family History: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

Disease / Condition	WHO	Disease / Condition	WHO
Retinal Detachment	☐ Y ☐ N	Glaucoma	☐ Y ☐ N _____
Blindness	☐ Y ☐ N	Cataracts	☐ Y ☐ N _____
Macular Degeneratio	☐ Y ☐ N	Diabetes	☐ Y ☐ N _____
Crossed Eyes	☐ Y ☐ N	Other Eye Problem	_____

Patient's Signature:_____ Date:_____

If Minor/Age 17 or less, Parent or Guardian:_____Date:_____
Physicians Signature:_____ Date:_____
History Reviewed. Additions as noted above.