LODESTAR
FAMILY EYE CARE, PC

JACOB FRANK, OD | KARA REYNOLDS, OD

GUIDING YOU TO BETTER VISION

ADULT PATIENT FORM

GENERAL INFORMATION

Full Name: ______________________ Preferred name: ______________

Date of Birth: ______________________ SSN: ______________

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Address: ______________________ Suite/Apt#: ______________

City: ______________________ State: ________ Zip: ________

Phone (home):____________ Phone (cell): ____________ Phone (work): ____________

E-mail: ______________________

Preferred Contact: ☐ Phone (home) ☐ Phone (cell) ☐ Phone (work) ☐ E-Mail

Employer: ______________________

Current Occupation: ______________________

Emergency Contact: ______________ Relationship: ________ Phone: ________

Reason for today's visit: ______________________

____

____

PRIMARY CONCERNS TODAY (or over the last week) (Check all that Apply)

☐ Allergies
☐ Foreign Body Sensation
☐ Burning/Stinging
☐ Loss of Vision
☐ Dryness
☐ Redness
☐ Flashes
☐ Glare/Sensitivity to Light
☐ Blurred Vision @ Near
☐ Itching
☐ Double Vision
☐ Pain/Discomfort
☐ Floaters/Spots
☐ Watering/Tearing
☐ Blurred Vision @ Distance
☐ Headache
☐ Discharge
☐ Loss of Side Vision
☐ Eye Strain/Fatigue
☐ Scratchy/Gritty Sensation

GLASSES

Do you wear glasses? ☐ Yes ☐ No If Yes, for? ☐ Near ☐ Distance ☐ Both

Type: ☐ Single Vision ☐ Progressive ☐ Bifocals ☐ Trifocals

Any Problems? ____

____

Do you have backup glasses? ☐ Yes ☐ No

Do you wear sunglasses? ☐ Yes ☐ No Do you have backup sunglasses? ☐ Yes ☐ No

CONTACTS

Do you wear contacts? ☐ Yes ☐ No If yes, type of contacts?

☐ Full Time
☐ Occasional
☐ Rarely

☐ Daily Wear
☐ Extended Wear
☐ Soft Toric

☐ Gas Permeable
☐ Bifocal/Progressive
☐ Colored

Any Problems? ____

____

What cleaning solution do you use? ____________________ Average wear time? ____________hours.

How often are they replaced? ________________ How old is your current pair? ________________

OCULAR HISTORY

Previous Eye Doctor: ______________________________ Last Exam: ______________

	Self	Family	Who?
Amblyopia (Lazy eye)	☐	☐	____________
Blindness	☐	☐	____________
Cataract(s)	☐	☐	____________
Color Deficiency	☐	☐	____________
Glaucoma	☐	☐	____________
Macular Degeneration	☐	☐	____________
Ptosis (Drooping Lid)	☐	☐	____________
Retinal Detachment	☐	☐	____________
Retinal Tear	☐	☐	____________
Strabismus (eye turn)	☐	☐	____________
Other	☐	☐	____________

History of Eye Surgeries (LASIK, PRK, cataract, other): ______________________________

History of Eye injuries: ______________________________

History of Eye Diseases: ______________________________

Are you interested in LASIK surgery at this time?

☐ Yes ☐ No If yes, would you like to speak to the Dr about your surgery options? ☐ Yes ☐ No

OCULAR SURFACE DISEASE SURVEY

Do your eyes ever feel or do you experience:	Never	Slight	Moderate	Severe
Gritty or sandy sensation?	☐	☐	☐	☐
Pain or soreness?	☐	☐	☐	☐
Fluctuating vision?	☐	☐	☐	☐
Occasional tearing?	☐	☐	☐	☐
Blurred vision while reading or computer use?	☐	☐	☐	☐
Discomfort in windy conditions?	☐	☐	☐	☐
Discomfort in heating/air conditioned areas?	☐	☐	☐	☐

ALLERGY SURVEY

Do you EVER suffer from red eyes, itchy eyes, watery eyes, or swollen eye lids?

☐ Yes ☐ No If yes, please list: ______________________________

Do you EVER use over-the-counter or prescribed eye drops (i.e. VISINE A, VISINE AC, OPCON A, etc.) to treat red eyes, itchy eyes, watery eyes, or swollen eye lids?

☐ Yes ☐ No If yes, please list: ______________________________

Do you take any prescribed or over the counter medications like CLARITIN, ALLEGRA, or ZYRTEC for your allergies?

☐ Yes ☐ No If yes, please list: ______________________________

MEDICAL HISTORY

Primary Care Physician: ______________________________ Last Physical: ______________

Do you have any allergies to medications? ☐ Yes ☐ No

If yes, please explain: ______________________________

Other Allergies (foods, pollens, etc.): ______________________________

Do you currently take any of the following medications? (Please check all that apply)

☐ Birth control pills ☐ Antihistamines ☐ Active bladder therapy
☐ Antidepressants ☐ Diuretics (Lasix) ☐ Accutane (even previously)
☐ Beta blockers ☐ Plaquenil ☐ Hormone replacement therapy

List any medications you take below (You may also provide your list of medications and we will make a copy to keep on file):

Rx or OTC/Supplements	Condition
______________________________	______________________________
______________________________	______________________________

MEDICAL

	Self	Family	Who?
Androgen Deficiency	☐	☐	______
Arthritis	☐	☐	______
Acne Rosacea	☐	☐	______
Diabetes	☐	☐	______
Cancer	☐	☐	______
Facial Herpes Zoster (Shingles)	☐	☐	______
Heart Disease	☐	☐	______
Hepatitis C	☐	☐	______
High Blood Pressure	☐	☐	______
Kidney Disease	☐	☐	______
Lupus	☐	☐	______
Migraines	☐	☐	______
Sarcoidosis	☐	☐	______
Sleep Disorders	☐	☐	______
Stroke	☐	☐	______
Thyroid Disease	☐	☐	______
Other	☐	☐	______

REVIEW OF SYMPTOMS: Please list any problems you are currently having anywhere, from head to toe.

General (e.g., fever, fatigue, loss of appetite, unexplained weight loss/gain):

______

Ear, Nose, Throat (e.g., sinus/nasal congestion, nose bleeds, dry mouth/throat, sleep apnea, hearing problems):

______

Cardiovascular (e.g., chest pain, racing heartbeat, swollen feet/ankles, TIAs):

______

Respiratory (e.g., chronic cough, shortness of breath, wheezing):

______

Genital, Kidney, Bladder (e.g., bladder/urinary problems, pain, discharge, menstrual changes, impotence):

______

Gastrointestinal (e.g., constipation. diarrhea, gastric reflux (GERD), jaundice, nausea, vomiting):

______

Endocrine (e.g., heat or cold intolerance, thinning hair, excess thirst, excess urination):

______

Muscles, Bones, Joints (e.g., pain, stiffness, swelling, weakness, limited movements):

______

Skin (e.g., dry, itchy, flaky, rash, growths, bumps, redness, discoloration):

____

Neurological (e.g., headaches, numbness/tingling, tremors, balance, dementia, speech problems):

____

Psychiatric (e.g., depression, anxiety, sleeping problems, paranoia, obsessive/compulsive):

____

Blood/Lymph (e.g., anemia, bleeding gums, delayed clotting, unexplained bruising):

____

Allergy/Immune (e.g., swollen lymph nodes, itching, sneezing, runny nose/eyes):

____

SOCIAL HISTORY

Do you drive? ☐ Yes ☐ No If yes, do you have visual difficulty when driving? ☐ Yes ☐ No

If yes, please describe: ____________________

Do you currently use smoke or smokeless tobacco? ☐ Yes ☐ No
If not now, have you ever smoked? ☐ Yes ☐ No

Drink alcohol? ☐ Yes ☐ No

Do you go to school? ☐ Yes ☐ No

If yes, where and grade level/field of study? ____________________

Do you play any sports? ☐ Yes ☐ No

If yes, what type and amount: ____________________

Other forms of exercise? ____________________

What are your hobbies? ____________________

How many hours per day do you:

Work on a computer: __________ Read: __________ Watch TV: __________ Play Video Games: __________

How did you hear about us? (please select all that apply):

☐ Walked/drove by building

Previous patient of: ☐ Dr. Reynolds ☐ Dr. Frank

☐ Professional referral (please specify): ____________________

☐ Family/Friend referral (please specify): ____________________

☐ Phone book ☐ Facebook ☐ Twitter ☐ Website ☐ Insurance company

☐ Promotion/advertisement (please specify): ______________________________

Print Name: ______________________________ Date: ______________

Signature: ______________________________