BISSELL Eye Care

Date:_____ Social Security # _____

Name:_____ Date of Birth:_____ Age: _____

Address:_____ City:_____ State:_____ Zip: _____

Home#:_____ Cell#:_____Work#:_____

E-mail:_____ Status: Married Single Divorced Widowed

Work Place/School:_____ Occupation/Grade: _____

Emergency Contact (Name/Phone): _____

Primary Language:_____ Race:_____ Ethnicity: _____

How did you hear about our office? _____

Primary Care Doctor:_____ Last exam:_____ Last Eye Exam:_____ Doctor: _____

Do you wear glasses?_____ How often do you wear sunglasses? _____

How old are your glasses?_____ Do you wear Contacts? (Brand/Power) _____

How many hours/day do you use the computer? _____ Do you get strain from computer work? _____

Social History: Tobacco: Type/Frequency? _____ Alcohol: Frequency? _____

Ocular History – please check all that apply

- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Glaucoma
- ☐ Diabetes
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye infection, Inflammation, Allergy
- ☐ Floaters/Flashes of light
- ☐ Iritis or Uveitis
- ☐ Retinal Defects or Degenerations
- ☐ Other: _____
- ☐ None

Vision and Eye Concerns

- ☐ Redness
- ☐ Burning
- ☐ Itching
- ☐ Tearing
- ☐ Discharge
- ☐ Blurred Vision
- ☐ Eye Strain
- ☐ Eye Pain
- ☐ Severe Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Total Loss of Vision
- ☐ Other: _____
- ☐ None

Immediate Family History – Please list Father, Mother, Brother, Sister or Children

- ☐ Blindness _____
- ☐ Lazy Eye _____
- ☐ Glaucoma _____
- ☐ Macular Degeneration _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Thyroid _____
- ☐ Other_____