Welcome to the office of Charles Shidlofsky, O.D. *PLEASE FILL OUT AS COMPLETE AS POSSIBLE*

☐ **Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.**

PERSONAL INFORMATION

☐ **MALE** ☐ **FEMALE**

Name Last		First	Middle Initial	Birth Date	
Address	Apt. #	City		State	Zip
Home Phone (Evening)	Business Phone (Day)	Last Eye Exam		Last Medical Exam	
Name of Parent, Spouse or Guardian	Name of Medical Doctor		Doctor's Phone Number		
Driver's License #	State	Social Security #	E-mail Address	Occupation	

MEDICAL HISTORY

List all major injuries, surgeries, and/or hospitalizations you have had:

List any medications you are currently taking (including aspirin / oral contraceptives / over the counter medications and home remedies):

List all medications you are allergic to:

Are you pregnant or nursing? ☐ Yes ☐ No

Do you wear glasses? ☐ Yes ☐ No If yes, how old is your present pair of glasses?

Do you wear contact lenses? ☐ Yes ☐ No If yes, how old is your present pair of lenses?

Type of contact ? ☐ Soft ☐ Extended Wear ☐ Rigid Gas Perm ☐ Other Are they comfortable? **Y** **N** ☐ Dry ☐ Blurry

REVIEW OF SYSTEMS

Do **YOU** currently, or have you ever had any problems in the following areas;

EYES	NO	YES	UNKNOWN
Past Eye Injury	☐	☐	☐
Loss of Vision	☐	☐	☐
Blurred / Distorted Vision	☐	☐	☐
Redness	☐	☐	☐
Itching	☐	☐	☐
Burning	☐	☐	☐
Excess Tearing / Watering	☐	☐	☐
Dryness	☐	☐	☐
Halos / Glare	☐	☐	☐
Eye Pain or Soreness	☐	☐	☐
Sandy or Gritty Feeling	☐	☐	☐
Foreign Body Sensation	☐	☐	☐
Chronic Infection of lid / eye	☐	☐	☐
Styes or Chalazion	☐	☐	☐
Mucous Discharge	☐	☐	☐
Flashes / **Floaters**	☐	☐	☐
Double Vision	☐	☐	☐
Tired Eyes	☐	☐	☐
Macular Degeneration	☐	☐	☐
Retinal Disease	☐	☐	☐
Cataracts	☐	☐	☐
Keratoconus	☐	☐	☐
Corneal Transplant	☐	☐	☐
Retinitis Pigmentosa	☐	☐	☐
Strabismus (crossed / lazy eye)	☐	☐	☐
CONSTITUTIONAL			
Fever, Weight loss / gain	☐	☐	☐
INTEGUMENTARY			
Skin			
Warts / Papilloma	☐	☐	☐
NEUROLOGICAL			
Headaches	☐	☐	☐
Migraines	☐	☐	☐
Seizures	☐	☐	☐

ENDOCRINE	NO	YES	UNKNOWN
Thyroid / Other Glands	☐	☐	☐
Cancer	☐	☐	☐
If yes, type:			
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	☐	☐	☐
Sinus Congestion	☐	☐	☐
Runny Nose / Post-Nasal Drip	☐	☐	☐
Chronic Cough	☐	☐	☐
Dry Throat / Mouth	☐	☐	☐
RESPIRATORY			
Asthma	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Emphysema	☐	☐	☐
CARDIOVASCULAR / **VASCULAR**			
Diabetes	☐	☐	☐
High Cholesterol / Hyperlipidemia	☐	☐	☐
High Blood Pressure	☐	☐	☐
Heart / Vascular Disease	☐	☐	☐
Heart / Chest Pain	☐	☐	☐
GASTROINTESTINAL			
Diarrhea	☐	☐	☐
Constipation	☐	☐	☐
GENITOURINARY			
Genitals / Kidney / Bladder	☐	☐	☐
BONES / **JOINTS** / **MUSCLES**			
Rheumatoid Arthritis	☐	☐	☐
Muscle Pain	☐	☐	☐
Joint Pain	☐	☐	☐
LYMPHATIC / **HEMATOLOGIC**			
Anemia	☐	☐	☐
Bleeding Problems	☐	☐	☐
PSYCHIATRIC	☐	☐	☐
OTHER			

If you answered YES to any of the above or have a condition not listed, please explain and list medications:

*** Please turn this form over and complete side two ***

SOCIAL HISTORY

This information is kept strictly confidential, however you may discuss this directly with the doctor if you prefer.

☐ Yes, I would prefer to discus my Social History directly with the doctor. (Check box)

Do you drive? ☐ NO ☐ YES If yes, do you have visual difficulty while driving? ☐ NO ☐ Yes If yes, describe:

Do you use tobacco products? ☐ Yes ☐ NO If yes type / amount / how long?

Do you drink alcohol? ☐ Yes ☐ NO If yes type / amount / how long?

Do you use illegal drugs? ☐ Yes ☐ NO If yes type / amount / how long?

Have you ever been exposed or infected with ☐ Syphilis ☐ Gonorrhea ☐ Hepatitis ☐ HIV (Please check if yes)

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:

DISEASE / CONDITION	NO	YES	UNKNOWN	RELATIONSHIP	COMMENTS
Blindness	☐	☐	☐		
Cataract	☐	☐	☐		
Crossed Eyes	☐	☐	☐		
Glaucoma	☐	☐	☐		
Macular Degeneration	☐	☐	☐		
Retinal Detachment	☐	☐	☐		
Retinal Disease	☐	☐	☐		
Arthritis	☐	☐	☐		
Diabetes	☐	☐	☐		
Heart Disease	☐	☐	☐		
High Blood Pressure	☐	☐	☐		
High Cholesterol	☐	☐	☐		
Kidney Disease	☐	☐	☐		
Lupus	☐	☐	☐		
Thyroid Disease	☐	☐	☐		
Other____					

INSURANCE INFORMATION

Name of Insurance Provider		Phone Number	Employer
Member ID#	Group #	☐ Primary ☐ Dependant	If Dependant, List Name and DOB of Primary

Doctors Signature

Date

ku 9/03