Dr. Michelle Barnes

Optometry

Miss. Mrs. Ms. Mr. Dr. Rev. Pronouns: _____ Single Married Divorced Separated Widowed

Patient Name: Last: _____First: _____Birthdate: ___/___/_____

Address: _____City, State Zip: _____

Home Phone: (____)_____ Cell: (_____)_____ Text Messaging: YES NO

Email: _____ Social Security #:_____Pharmacy:_____

Employer/School:_____Occupation/Grade:_____

Parent/ Guardian if a minor: _____

Vision Insurance & ID#: _____Health Insurance & ID#: _____

Medical Doctor:_____ Year of Last Exam: _____

Last Eye Doctor: _____Year of Last Exam: _____

Personal Health History (Please circle or list any and all known problems): Check here if NONE ☐

Headaches/Migraine Sinusitis Heart Disease Hypertension High Cholesterol

COPD/ Asthma Kidney Disease Gerd/ IBS/ Crohn's Thyroid Dysfunction PCOS

Arthritis/ Rheumatoid Seizures Vertigo ADHD Anxiety/Depression

Anemia Cancer: (specify)_____Diabetes: Year Diagnosed_____ A1C_____

Other Health Diagnosis: _____

Smoke Vape Snuff/ Chew: Every Day Occasionally Former Quit Date_____

Alcohol: YES NO Occasionally Daily

Are you Pregnant or Nursing? YES NO How far along if Pregnant:_____

Any Special Needs? YES NO Type:_____

Medications/ Supplements: _____

_____

_____

Surgeries: _____

_____

Allergies: _____

Do you wear Glasses? YES NO How long have you had your current pair? _____

Do your glasses have a: Progressive bifocal Transition Lens Prism Lens

Do you wear Contacts? YES NO Soft Hard Two-week Monthly Specialty

Name/ Brand of Contacts_____ Power of Contacts: _____

Current Eye Problems: (Circle all that apply) Check here if NONE ☐

Blurred Distance Vision Blurred Near Vision Flashes Floaters Double Vision

Strain Itching Burning Sandy/ Gritty Redness Pain/ Soreness

Halos/Glare Light Sensitivity Discharge/ Mucus

Personal Eye History: (Please list **any** and *all* known eye problems): Check here if NONE ☐

Glaucoma Cataracts Keratoconus Macular Degeneration Allergies

Dry Eye Retinal Detachment Diabetic Retinopathy Lazy Eye/ Amblyopia

Eye Injury: (When and which eye) _____

Eye Surgeries: (Please List) _____

Prescription or OTC Eye drops:_____

Family Medical History: (Circle ALL that apply)

Diabetes: Mother Father Sibling Grandparent

High Blood Pressure : Mother Father Sibling Grandparent

Thyroid: Mother Father Sibling Grandparent

Cardiovascular Disease: Mother Father Sibling Grandparent

Cancer: Mother Father Sibling Grandparent

Family Eye History: (Circle ALL that apply)

Glaucoma: Mother Father Sibling Grandparent

Macular Degeneration: Mother Father Sibling Grandparent

Retinal Detachment: Mother Father Sibling Grandparent

Cataracts: Mother Father Sibling Grandparent

Amblyopia/ Crossed eyes: Mother Father Sibling Grandparent

Other: _____ Mother Father Sibling Grandparent