WELCOME TO OUR OFFICE

Please fill out this form as completely as possible and return it to the desk

Dr. Steven R. Fields

Today's Date ____ / ____ / ____

Name ____________________

Email Address ____________________

Address ____________________

Home Phone ____________________

Apt. # ____________________

☐ Male ☐ Female

Cell Phone ____________________

City ____________________

State ____________________

Work Phone ____________________

Zip Code

Date of Birth / /

SSN

Primary Care Physician ____________________

Phone Number ____________________

Previous Eye Doctor ____________________

Phone Number ____________________

Last Eye Exam

Referred By

Employer ____________________

Occupation ____________________

Emergency Contact

Phone Number

☐ I wear Glasses ☐ I wear Contacts ☐ Soft ☐ Hard Brand

MEDICAL HISTORY

Allergies ____________________

Ocular History ____________________

Medications: ____________________

Injuries/Surgeries ____________________

____ Anxiety	____ Renal Disease	____ Seizures
____ Arthritis	____ GERD	____ Stroke
____ Asthma	____ Hearing Loss	
____ Atrial Fibrillation	____ Hepatitis	Other Medical Issues
____ Bone Marrow Trans.	____ Hypertension	
____ BPH	____ HIV/AIDS	
____ Breast Cancer	____ High Cholesterol	
____ Colon Cancer	____ Leukemia	
____ COPD	____ Lung Cancer	
____ Corn. Artery Disease	____ Lymphoma	
____ Depression	____ Prostate Cancer	
____ Diabetes	____ Radiation	

FAMILY MEDICAL HISTORY: Note relation to yourself in the box (ex: mother, paternal grandfather)

Blindness		Cancer	
Cataracts		Diabetes	
Macular Degeneration		Heart Disease	
Glaucoma		High Blood Pressure	
Retinal Dettachment		Kidney Disease	
Cross Eyed		Arthritis	
Lupus		Thyroid Disease	
Other			

Social History

Do you Drive?	Yes	No	Do you use Tobacco?	Yes	No
How Often?			Type? How Long?		
Difficulties?					
Do you Drink Alcohol?	Yes	No	Do you use Illegal Drugs?	Yes	No
Type? How Long?			Type? How Long?		

Have you ever been exposed to or infected with? ☐ Gonhorrehea ☐ Hepatitis ☐ Syphilis ☐ HIV

Review of Systems

Eyes	Gastrointestinal	Endochrine	Please list any other symptoms you may be experiencing.
___ Vision Loss	___ Colitis	___ Non Insulin Diabetes	
___ Blurred Vision	___ Crohn's Disease	___ Insulin Diabetes	
___ Distorted Vision	___ Olcers	___ Thyroid Dysfunction	
___ Double Vision	___ Consitipation	___ Hormonal Dysfunction	
___ Dryness	___ Diarrhea	**Respiratory**	
___ Redness	**Constitutional**	___ Asthma	
___ Mocous Discharge	___ Fever	___ Bronchitis	
___ Gritty Feeling	___ Weight Loss	___ Emphysema	
___ Itching	___ Fatigue	**Cardiovascular**	
___ Burning	___ Trauma	___ Heart Disease	
___ Excess Watering	**Skin**	___ Hypertension	
___ Light Sensitivity	___ Eczema	___ Hypercholsterolemia	
___ Eye Pain	___ Rosacea	**Ears/Nose/Throat**	
___ Chronic Infection	___ Psoriasis	___ Allergies	
___ Sties	**Neurological**	___ Sinus Congestion	
___ Flashes	___ Headache	___ Runny Nose	
___ Floating Spots	___ Migraines	___ Post Nasal Drip	
___ Cataracts	___ Seizures	___ Chronic Cough	
___ Glaucoma	___ Multi. Sclerosis	___ Dry Throat/Mouth	
___ Diabetic Retinopathy			
___ Mascular Degenration			
___ Retinal Detachment			