

# Dr. David J. Sheinkopf & Dr. Thomas D. Tomasik

Please complete the following confidential information. This information is extremely important for proper treatment. If you would like assistance in completing this form, our staff will be happy to assist you.

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Legal Name \_\_\_\_\_ Exam Date \_\_\_\_\_ OM# \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Home Phone \_\_\_\_\_ Day Phone \_\_\_\_\_ Ext. \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Marital Status: M S W D Significant other \_\_\_\_\_ Referred By \_\_\_\_\_  
Occupation/ Employer or School \_\_\_\_\_ SS # \_\_\_\_\_  
Financially Responsible Party \_\_\_\_\_ If Child, Parent/ Guardian Name \_\_\_\_\_  
Address ( If Different ) \_\_\_\_\_ E-mail \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Vision Insurance \_\_\_\_\_ Medical Insurance \_\_\_\_\_  
Last Eye Exam \_\_\_\_\_ Last Physical Exam \_\_\_\_\_

**Reason for Exam** (Please circle) Routine - Cataract – Diabetes - Contact Lenses - Refractive Surgery

**Are you having problems with: (Please check, if yes, please note which eye)**

<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Eye Injury	<input type="checkbox"/> Mucous Discharge	<input type="checkbox"/> Itching	<input type="checkbox"/> Burning
<input type="checkbox"/> Changes in Vision	<input type="checkbox"/> Flashes	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Tearing	<input type="checkbox"/> Loss of Vision
<input type="checkbox"/> Difficulty Driving	<input type="checkbox"/> Floaters	<input type="checkbox"/> Dryness	<input type="checkbox"/> Glare	<input type="checkbox"/> Loss of Side Vision
<input type="checkbox"/> Difficulty Reading	<input type="checkbox"/> Lid Swelling	<input type="checkbox"/> Redness	<input type="checkbox"/> Headaches	<input type="checkbox"/> Fluctuating Vision
<input type="checkbox"/> Double Vision	<input type="checkbox"/> Halos	<input type="checkbox"/> Soreness	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other _____

**Eye History: (Please check, if yes, please note which eye and how long or when)**

<input type="checkbox"/> Amblyopia / Lazy Eye R / L	<input type="checkbox"/> Glaucoma R / L	<b>Eye Surgery: (Doctor and Approx. Date)</b>
<input type="checkbox"/> Strabismus/ Eye Turn R / L	<input type="checkbox"/> Macular Degeneration R / L	<input type="checkbox"/> Cataracts R / L by Dr. _____
<input type="checkbox"/> Blindness R / L	<input type="checkbox"/> Retinal Problems R / L	<input type="checkbox"/> Glaucoma R / L by Dr. _____
<input type="checkbox"/> Color Blindness	<input type="checkbox"/> Eye Injury R / L	<input type="checkbox"/> Retinal Surgery R / L by Dr. _____
<input type="checkbox"/> Cataracts R / L	<input type="checkbox"/> Corneal Problem R / L	<input type="checkbox"/> Laser Surgery R / L by Dr. _____

**Social History:**

Tobacco use Y / N  Alcohol use Y / N

**Medical History:**

<input type="checkbox"/> Diabetes - Since _____	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Neurological	<input type="checkbox"/> Blood disorders
<input type="checkbox"/> Hypertension - Since _____	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Endocrine	<input type="checkbox"/> Skin/ breasts
<input type="checkbox"/> Cardiovascular (heart, cholesterol)	<input type="checkbox"/> Musculoskeletal	<input type="checkbox"/> Psychiatric	<input type="checkbox"/> Constitutional
<input type="checkbox"/> Ears, nose, throat	<input type="checkbox"/> Genitourinary		
<input type="checkbox"/> Allergies (Please list all, including specific medications) _____			

Please list all medications you are currently taking: \_\_\_\_\_

**Are you currently using any eye drops:** Yes / No If so, please list them \_\_\_\_\_

**Family Medical and Ocular History: (Please circle)**

Diabetes	Heart Disease	Glaucoma	Color Blindness	Retinal Problems
Hypertension	Cancer	Cataract	Corneal Problems	Other _____

**No changes in my ocular or medical history or medications since \_\_\_\_\_ . Initial \_\_\_\_\_ Date \_\_\_\_\_**