

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.

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)

Blurred Vision Eye Injury Mucous Discharge Itching Burning
Changes in Vision Flashes Eye Pain Tearing Loss of Vision
Difficulty Driving Floaters Dryness Glare Loss of Side Vision
Difficulty Reading Lid Swelling Redness Headaches Fluctuating Vision
Double Vision Halos Soreness Migraines Other \_\_\_\_\_

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

Amblyopia / Lazy Eye R / L Glaucoma R / L Eye Surgery: (Doctor and Approx. Date)
Strabismus/ Eye Turn R / L Macular Degeneration R / L Cataracts R / L by Dr. \_\_\_\_\_
Blindness R / L Retinal Problems R / L Glaucoma R / L by Dr. \_\_\_\_\_
Color Blindness Eye Injury R / L Retinal Surgery R / L by Dr. \_\_\_\_\_
Cataracts R / L Corneal Problem R / L Laser Surgery R / L by Dr. \_\_\_\_\_

Social History:

Tobacco use Y / N Alcohol use Y / N

Medical History:

Diabetes - Since \_\_\_\_\_ Respiratory Neurological Blood disorders
Hypertension - Since \_\_\_\_\_ Gastrointestinal Endocrine Skin/ breasts
Cardiovascular (heart, cholesterol) Musculoskeletal Psychiatric Constitutional
Ears, nose, throat Genitourinary
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 \_\_\_\_\_