

Do you have pain today? _____ If yes, where is the pain _____

What is your pain level today on a scale from 0-1-2-3-4-5-6-7-8-9-10?

Have you ever had a fall? _____ **If yes, when was it and did you get hurt?** _____

1. When was your last examination **with an eye doctor?** _____
2. What is the **main reason** for your visit today? *(Please explain):* _____
3. Do you wear glasses? _____ Do you wear Contact lenses? _____
4. Have you ever had **eye trauma?** **YES** **NO** _____
5. Have you ever had **eye surgery?** **YES** **NO** _____
6. Have you had Laser eye surgery: **YES** **NO** **If yes, when was it:** _____
7. Are you **allergic** to any medications? **YES** **NO** – *please list* _____
8. Have **you** ever been diagnosed with any of the following diseases?

- | | | | | | |
|-----------------------|-------------------------------------|------------------------------------|----------------------|-------------------------------------|------------------------------------|
| Amblyopia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Strabismus (eye turn) | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Macular degeneration | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Asthma | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hyperlipidemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hypertension | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid | <input type="checkbox"/> YES | <input type="checkbox"/> NO | Autoimmune | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

9. (AD ARMY ONLY) Are you here to update your medpros? **YES** **NO**

10. Do you drink alcohol? **YES** **NO**
11. Do you smoke? **YES** **NO** – *how many packs per day?* _____
12. Are you pregnant? **YES** **NO**
13. Does anyone in your **family** have any of the following conditions? *(If yes, please list relationship)*

- | | | | | | | | |
|-------------------------|-------------------------------------|------------------------------------|-------|-------------------|-------------------------------------|------------------------------------|-------|
| A. Blindness | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | D. Diabetes | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| B. Glaucoma | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | E. Hyperlipidemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |
| C. Macular degeneration | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ | F. Hypertension | <input type="checkbox"/> YES | <input type="checkbox"/> NO | _____ |

DISTANCE VISION:

Uncorrected vision: OD 20/ _____ *OD PH* _____ OS 20/ _____ *OS PH* _____ OU 20/ _____

Corrected vision: OD 20/ _____ *OS PH* _____ OS20/ _____ *OS PH* _____ OU 20/ _____

NEAR VISION:

Uncorrected vision: OD 20/ _____ OS 20/ _____ OU 20/ _____

Corrected vision: OD 20/ _____ OS20/ _____ OU 20/ _____

Habitual RX: Habitual RX:
OD: _____ OD: _____

OS: _____ OS: _____

Contact Lens Brand: _____
OD _____ OS _____
BC: _____ DIA: _____
Average Wear: _____
Solution type: _____

NCT:
OD _____ Time: _____
OS _____

Patients Identification:

Full Name: _____ Rank: _____

Date of Birth: _____ Full SSN: _____