Paul W. Hottel, O.D.
John W. Weihe, O.D.
Nicholas J. Olberding, O.D.
Sheri L. Roggy, O.D.
Jayme N. Wilhelm, O.D.
Dennis J. Schlader, O.D.

EYE ASSOCIATES
Life is how you *see* it.

Today's Date: _____

GENERAL INFORMATION

Name (First, MI, Last & Preferred): _____ Date of Birth: _____
Address: _____ Gender: □ Male □ Female
City, State, Zip: _____
Social Security #_____

Please list your Phone #, then check which # you prefer to be contacted:
□ Home: _____ □ Work: _____ □ Cell: _____
E-mail: _____

Race (please circle): Caucasian African American Hispanic/Latino Asian Indian
Multiracial American Indian Hawaiian African Arab Unknown
Ethnicity (please circle): Hispanic/Latino Not Hispanic/Latino
Language: _____
Employer (or School): _____ Occupation (or Grade):_____
Emergency Contact and Phone #:_____
If married, name of spouse_____ If child, name of parents_____

EYE HEALTH HISTORY:

Last eye exam: _____ Doctor/Location:_____
Do you currently wear contact lenses? □ Yes □ No. If yes, what kind?_____
Do you wear glasses? □ Yes □ No. If yes, how old are they?_____

Have you been experiencing any of the following?

□ Blurred Vision
□ Flashes
□ Floaters
□ Light Sensitivity
□ Burning/Sandy Feeling
□ Dry Eyes
□ Redness
□ Tired/Strained Eyes
□ Itching
□ Watery Eyes

Are you interested in?

□ Contact Lenses
□ Lasik
□ Computer glasses
□ Sports glasses
□ Sunglasses

Any specific visual/eyewear needs for your work or hobbies? _____
Do you currently work at a computer for long periods? How long per day? _____

Is there a family history of any of the following? (Explain relationship)

□ Glaucoma _____
□ Macular Degeneration _____
□ Cataracts _____
□ Retinal Detachment/Tear _____
□ Lazy Eye_____
□ Other Eye Disease_____
□ Type II Diabetes _____
□ Type I Diabetes_____
□ Hypertension_____
□ Cancer_____
□ Hyperthyroid_____
□ Hypothyroid_____

Current Medications (Include over-the-counter, eye drops/meds, vitamins, oral contraceptives)

_____

_____

_____

_____

_____

Have you experienced or been diagnosed or treated for: (If yes, check box and explain below)

EYES
□ Cataracts
□ Glaucoma
□ Macular Degeneration
□ Dry Eye Syndrome
□ Retinal Tear/Detachment
□ Lazy Eye
□ Eye Injury
□ Eye Surgery/LASIK

CONSTITUTIONAL
□ Developmental Disability
□ Cancer

EAR/NOSE/THROAT
□ Hearing Loss
□ Sinusitis

NEUROLOGICAL
□ Multiple Sclerosis
□ Stroke
□ Migraines
□ Concussion

PSYCHIATRIC
□ Depression
□ Anxiety Disorder
□ Bipolar Disorder

CARDIOVASCULAR
□ High Blood Pressure
□ Heart Disease
□ Vascular Disease

RESPIRATORY
□ Asthma
□ COPD
□ Sleep Apnea

GASTROINTESTINAL
□ Crohn's, Colitis

GENITOURINARY
□ Kidney Disease
□ Sexually Transmitted Disease

MUSCULOSKELATAL
□ Osteoarthritis

SKIN
□ Rosacea
□ Eczema/Psoriasis

ENDOCRINE
□ Diabetes
□ Thyroid dysfunction

HEMATOLOGIC/LYMPHATIC
□ Anemia
□ High Cholesterol

ALLERGY/IMMUNOLOGIC
□ Rheumatoid Arthritis
□ Lupus

OTHER: _____

Please Explain: _____

Primary Physician:_____ Clinic/Location:_____Last Exam:_____

Height:_____Weight:_____

If female: Are you currently pregnant? Yes or No Are you Nursing? Yes or No

Allergies

Are you allergic to any medications? □ Yes □ No. If yes: _____

Do you have any environmental allergies/hay fever? □ Yes □ No

Social History:

Do you use any tobacco products? □ Yes □ No How often_____ Have you ever smoked? □ Yes □ No

Do you drink alcohol? □ Yes □ No How often_____

How did you hear about our office? (Please check box and list name)

□ Friend/Relative: _____□ Another Healthcare Provider: _____

□ Internet: _____□ Event/Other: _____