BANKS' FAMILY EYE CLINIC, PLLC
Nick Banks, OD

General Information Date: ____/_____/______

Last Name________________________ First Name: ______________M ______DOB: ___/___/___

M or F SSN: ______ /_____ /_______ Marital Status: Married / Single / Divorced / Widowed

Address: ______________________________ City: __________________ State: _______ Zip: _______

Home Ph: ( ) _______________ Work Ph: ( ) _______________ Cell Ph: ( ) ______________

Employer/School:_______________________ Occupation/School Grade:_____________________

E-mail Address:___________________________ Sports/Hobbies: ____________________________

Emergency Contact: _______________________ Relation: _____________ Phone #: ( ) __________

CASE HISTORY / REASON FOR VISIT:

Date of Last Medical Exam:____/____/____ Primary Physician/Clinic:______________________________

Date of Last Eye Exam:____/_____/_____ Clinic/Eye Doctor's Name:______________________________

Do you wear glasses? Yes/No/All the time/Sometimes/Work Only/Reading only/Driving only

How old are your present glasses: _______________________ Do you wear prescription Sun Wear: Yes/No

Do you wear contacts? Yes No Type:____________________ Solution Used: _____________________

Wearing schedule: **Daily** **Overnight** Replacement schedule: **Daily** **2 week** **Monthly** **Yearly**

Have you ever had eye injuries? Yes No Which Eye?____

Have you ever had eye surgeries? Yes No Why?____

Have you used eye medication? Yes No Why?____

Are you currently pregnant or nursing? Yes No N/A

Have you ever been diagnosed with?

Cataracts: Yes/No When were you diagnosed?____________________________________

Glaucoma: Yes/No When were you diagnosed?____________________________________

Macular Degeneration: Yes/No When were you diagnosed?____________________________________

What are your visual symptoms (with or without glasses or contacts)? Please circle any that apply:

Please indicate Right, Left or Both, along with severity 1(Low) 2 (Moderate) 3 (High)

In Example: [2] Eye Strain R L (B) This example indicates a moderate severity in both eyes

[ ] Blurred Vision/Distance	R L B	[ ] Dry Eyes	R L B	[ ] Headaches	R L B
[ ] Blurred Vision/Near	R L B	[ ] Red Eyes	R L B	[ ] Migraine Headaches	R L B
[ ] Double Vision	R L B	[ ] Watery Eyes	R L B	[ ] Loss of Vision	R L B
[ ] Eye Strain	R L B	[ ] Wandering eye	R L B	[ ] Crossed Eyes	R L B
[ ] Eye Infections	R L B	[ ] Mucus Discharge	R L B	[ ] Light Sensitive	R L B
[ ] Eye Pain/Soreness	R L B	[ ] Floaters or Spots	R L B	[ ] Sandy/Gritty Feeling	R L B
[ ] Tired eyes	R L B	[ ] See Flashes	R L B	[ ] Poor Color Vision	R L B
[ ] Burning Eyes	R L B	[ ] See Halos	R L B	[ ] Droopy Lid	R L B
[ ] Itchy Eyes	R L B	[ ] Poor Night Vision	R L B		

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Please turn over and complete other side

Patient Name____________________

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS) : PLEASE CHECK IF ANY OF THE FOLLOWING **APPLIES** TO YOU, AND LIST ANY MEDICATIONS FOR EACH CONDITION THAT YOU CHECK. IF YOU HAVE NONE OF THESE CONDITIONS, **PLEASE CHECK NONE.**

Cardiovascular: __ **None** ___ Hypertension ___ Stroke ___ Heart Disease ___ Vascular Disease ___ Other:	**Endocrine:** __ **None** ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	**Respiratory:** __ **None** ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
Constitutional: __ **None** ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	**Ocular** __ **None** ___ Glaucoma ___Macular Degeneration ___Detached Retina ___ Other:	**Psychiatric:** __ **None** ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
Neurological: __ **None** ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	**Musculoskeletal:** __ **None** ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	**Immunologic:** __ **None** ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Neurofibromatosis ___ Other:
Hematological: __ **None** ___ Anemia ___ Leukemia ___ Other:	**Gastrointestinal** __ **None** ___ Crohn's ___ Colitis ___ Other:	**Ear/Nose/Throat:** __ **None** ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
Dermatologic: __ **None** ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	**Allergies** (please list) __ **None** Drug: Environmental:	 **Alcohol Use:** Y N Amount: **Tobacco Use:** Y N Amount:

Please list physical reaction's to above allergies: ____________________

Please list any medications and/or drugs that you are taking (including herbal) : See Attatched List: ________

1 ________	**For** ________	**6** ________	**For** ________
2 ________	**For** ________	**7** ________	**For** ________
3 ________	**For** ________	**8** ________	**For** ________
4 ________	**For** ________	**9** ________	**For** ________
5 ________	**For** ________	**10** ________	**For** ________

FAMILY HISTORY: Has anyone in your family (grandparents, parents, siblings, children, living or deceased) been diagnosed with:

DISEASE / CONDITION		WHO	DISEASE / CONDITION		WHO
Retinal Detachment:	Yes/No	________	Blindness:	Yes/No	________
High Blood Pressure:	Yes/No	________	Cataracts:	Yes/No	________
Diabetes:	Yes/No	________	Glaucoma:	Yes/No	________
Cancer:	Yes/No	________	Crossed Eyes:	Yes/No	________
Heart Disease:	Yes/No	________	Macular Degen:	Yes/No	________
Thyroid Disease:	Yes/No	________	Lupus	Yes/No	________

Reviewed by:

Dr ____________________ Date ____________________

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