OPTOMETRIC IMAGES VISION CARE

Dr. Randall S. Ramsey - Dr. Gary K. Ozaki- Dr. Shivani Ram

General Information

Patient Name_____ Date_____
Address_____City_____State_____Zip_____
Cell Phone_____Home_____Work_____
Date of Birth_____Occupation_____Employer_____
Emergency Contact Name_____Phone_____

Chief Complaint: How can we help you? In the space below, please briefly tell us any signs and symptoms you are experiencing.

History of Present Illness: Please tell us more about your signs and symptoms. Use the words below to help describe your problem.

Location_____
Severity_____
When did it start? _____Duration? _____
Did the problem develop suddenly or gradually? _____
Since noticing, has it gotten worse? _____
Are the symptoms constant or intermittent? _____
Have you recently had an accident or injury? _____

Symptoms check/circle all that apply

[ ] Blurred Vision	[ ] Discomfort/Pain	mild	severe
[ ] Double Vision	[ ] Itching	mild	severe
[ ] Floaters	[ ] Redness	mild	severe
[ ] Flashes of light	[ ] Discharge	mild	severe
[ ] Steamy or Cloudy Vision	[ ] Headaches	mild	severe
[ ] Halos around lights	[ ] Light Sensitivity	mild	severe
[ ] Missing areas in vison	[ ] Other_____		

Review of Systems: Have you or any family member had difficulty in any of the following body systems?

	Self	Family		Self	Family
Constitutional Systems	[ ]	[ ]	Allergic/Immunologic	[ ]	[ ]
i.e., fever, weight loss			Musculoskeletal	[ ]	[ ]
Eyes	[ ]	[ ]	Integumentary	[ ]	[ ]
Ears, Nose,Throat,Mouth	[ ]	[ ]	i.e., Skin or breast		
Cardiovascular	[ ]	[ ]	Neurological	[ ]	[ ]
Respiratory	[ ]	[ ]	Psychiatric	[ ]	[ ]
Gastrointestinal	[ ]	[ ]	Endocrine	[ ]	[ ]
Genitourinary	[ ]	[ ]	Hematologic/Lymphatic	[ ]	[ ]

Past, Family and/or social history: Is there anything in your past history, family history, or social history which would help us care for you?

Past History: _____
Family History: _____
Social History: _____