WELCOME TO OUR OFFICE
Ann K. Miyamura, O.D., Inc.

Name_____ Last Exam _____ Today's Date _____

Street_____ Date of Birth _____ Sex M F

City, State, ZIP_____ Email_____

Phone (Hm)_____ (Cel)_____ (Wk)_____

Primary Insured _____ SSN_____ Referred by_____

Physician name_____ Ph:_____

Emergency contact_____ Ph:_____ Relationship_____

Reason for eye exam: Glasses Contacts Both Other_____

If you wear contacts, what brand?_____ Power (if known)_____

Are you allergic to any medications? N Y If Yes, list_____
Are you pregnant and/or nursing? N Y

List any prescription or over the counter medications you are taking (including oral contraceptives, allergy medication, aspirin, vitamins / supplements, and eye drops)_____
_____
_____

Patient Eye History – Do you have any of the following? (check those you have)

___Burning	___Redness	___Dryness	___Itchy Eyes	___Tearing
___Floaters	___Flashes of light	___Gritty sensation	___Double vision	___Headaches
___Sudden vision loss	___Light sensitivity	___Glare/halo at night	___Eyestrain	___Eye pain
___Eyelid twitching	___Lazy Eye	___Other (explain)_____		
___Injury/surgery, if so what kind and when?		_____		

Family Medical History – Have any of your blood relatives (living or deceased) had any of the following:
(Mark M=mother, F=father, S=sibling, GP= grandparent)

Cataracts	N	Y	Who_____	High Blood Pressure	N	Y	Who_____
Glaucoma	N	Y	Who_____	Diabetes	N	Y	Who_____
Lazy Eye	N	Y	Who_____	Macular Degeneration	N	Y	Who_____

Review of Systems – Do **you** have any of the following? (If so, please describe)

Neurological	N	Y	(MS, seizures, etc) _____
Ear/Nose/Throat	N	Y	(sinus, ear infection etc) _____
Cardiovascular	N	Y	(heart disease, etc) _____
Respiratory	N	Y	(asthma, emphysema, etc) _____
Gastro-Intestinal	N	Y	(ulcer, stomach etc) _____
Genital-Kidney -Bladder	N	Y	(STDs, etc) _____
Muscle – Bone -Joints	N	Y	(arthritis, etc) _____
Skin	N	Y	(eczema, rosacea, etc) _____
Psychiatric	N	Y	(anxiety, depression, etc) _____
Endocrine	N	Y	(diabetes, thyroid, etc) _____
Lymph-Blood	N	Y	(anemia, etc) _____
Allergic -Immunologic	N	Y	(hayfever, lupus, food,etc)_____

Reviewed no changes from last visit (initial) _____ _____ _____