84 Second Street, Leechburg PA 15656
724.845.7777

Duppstadt
vision associates

www.duppstadtvisionassociates.com

Name____ Today's Date______________________

Address____ Phone: __________________________

____ Work Phone:______________________

Birthdate__________________ Social Security #_____________________ Last Eye Exam:____________________

Name of Medical Doctor_______________________________________ Dr. Phone:_______________________

Medical Insurance____ Last Medical Exam:________________

Vision Insurance____

Medical History

List any medications you take (including oral contraceptions, over the counter medications and home remedies:)

____

List all major injuries, or operations to your eyes: ____

____

List any of the following that you have had:

- ☐ crossed eyes
- ☐ lazy eye
- ☐ glaucoma
- ☐ retinal disease
- ☐ cataracts
- ☐ eye infections
- ☐ eye injuries
- ☐ macular degeneration

Have you considered:

- ☐ Contact Lenses
- ☐ Sun Glasses or Clip-ons
- ☐ Progressive Lenses
- ☐ Refractive Surgery

Do you have a problem with any of the following:

- ☐ Glare from headlights
- ☐ Brightness during the day
- ☐ Computer Lenses
- ☐ Intermediate Vision (i.e. dashboard, store shelves, etc.)

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) ***for following conditions:***

DISEASE/CONDITION	*RELATIONSHIP TO YOU*
☐ Blindness	______________________
☐ Cataract	______________________
☐ Crossed Eyes	______________________
☐ Glaucoma	______________________
☐ Macular Degeneration	______________________
☐ Retinal Detachment/Disease	______________________
☐ Arthritis	______________________
☐ Cancer	______________________
☐ Diabetes	______________________
☐ Heart Disease	______________________
☐ High Blood Pressure	______________________
☐ Kidney Disease	______________________
☐ Lupus	______________________
☐ Thyroid Disease	______________________
☐ Other______________	______________________
☐ Other______________	______________________
☐ Other______________	______________________

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Social History

Do you drive? ☐ no ☐ yes If yes, do you have difficulty when driving? ☐ no ☐ yes If yes, please describe:

____

Do you use tobacco products? ☐ no ☐ yes If yes, type/amount/how long: ______________________

Do you drink alcohol? ☐ no ☐ yes If yes, occasionally, moderately, frequently

Vacation (What do you do) ____

Hobbies ____

Sports or Outdoor Activities ____

Review of Systems

Constitutional ***None_____***
- ☐ Development Disability
- ☐ Weight Loss/Gain
- ☐ Fever
- ☐ Fatigue
- ☐ Cancer

Ear, Nose, Mouth, Throat ***None_____***
- ☐ Upper Respiratory Tract Infection
- ☐ Sinus Congestion
- ☐ Dry Throat/Mouth

Vascular/Cardiovascular ***None_____***
- ☐ Heart Disease
- ☐ High Cholestrol
- ☐ High Blood Pressure
- ☐ Stroke

Respiratory ***None_____***
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Integumentary (skin) ***None_____***
- ☐ Eczema
- ☐ Rosacea

Neurological ***None_____***
- ☐ MS (Multiple Sclerosis)
- ☐ Headaches
- ☐ Migranes
- ☐ Seizures

Eyes ***None_____***
- ☐ Muscle Surgery
- ☐ Cataract
- ☐ Glaucoma
- ☐ Loss of Vision
- ☐ Macular Degeneration
- ☐ Double Vision
- ☐ Loss of Side Vision
- ☐ Distoreted Vision/Halos
- ☐ Dryness
- ☐ Nucos Discharge
- ☐ Redness
- ☐ Sandy or Gritty Feeling
- ☐ Itching
- ☐ Burning
- ☐ Foreign Body Sensation
- ☐ Excess Tearing/Watering
- ☐ Glare/Light Sensitivity
- ☐ Eye Pain or Soreness
- ☐ Chronic Infection of Eye or Lid
- ☐ Sties or Chalazion
- ☐ Flashes/Floaters in Vision
- ☐ Tired Eyes

Endocrine ***None_____***
- ☐ Thyroid/Other Glands
- ☐ Diabetes • insulin dependent
- ☐ Diabetes • non insulin dependent

Gastrointestinal ***None_____***
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer

Genitourinary ***None_____***
- ☐ Urinary Tract Infection
- ☐ Kidney Ailments

Bones/Joints/Muscles ***None_____***
- ☐ Rheumatoid Arthritis
- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Muscular Dystrophy

Lymphatic/Hematologic ***None_____***
- ☐ Anemia
- ☐ Bleeding Problems

Allergic/Immunologic ***None_____***
- ☐ Lupus
- ☐ Hay Fever
- ☐ ____________________
- ☐ ____________________
- ☐ ____________________

Psychiatric ***None_____***
- ☐ ____________________
- ☐ ____________________