



Broadway Eye Center

Ver 8/10

Patient's name: _____ **Occupation:** _____

Vision Needs: _____ **Hobbies:** _____

Main reason for today's visit: _____

Current (in last month) vision problems:

- Poor vision at distance with lenses
- Poor vision at computer with lenses
- Poor vision at near with lenses
- Other _____

Current (in last month) eye health problems:

- Eye fatigue or soreness
- Eye(s) watery
- Pain, heavy or pressure feeling
- Eye(s) discharge (mucus or filmy)
- Foreign body sensation (something in eye)
- Blinking/twitching
- Eye(s) dry/sandy feeling
- Double vision
- Eye(s) redness
- Loss of vision (temporary)
- Eye(s) burning
- Floaters/Flashes
- Eye(s) itching
- Headache/migraine
- Eyelid(s) puffy/swollen
- Pain near eye(s)
- Eyelids(s) droopy/baggy
- Sensitivity to light
- Eyelids(s) crusty
- Contact lenses bother eye(s)

Self or family member's history:

Self Family

- Amblyopia (lazy eye)
- Cataracts
- Color vision problems
- Corneal problems
- Glaucoma
- Macular degeneration
- Retinal detachment
- Eye surgery _____
- Other eye disease _____
-
- Arthritis
- Bad reaction (allergies) to medicine
- Diabetes Child onset Adult onset
- High blood pressure
- Thyroid problem
- Other _____

Self

- Allergy or reaction to medication
- Cardiovascular (heart or vessel) problem
- Constitution (fever, weight loss) problem
- Endocrine or gland problem
- Gastrointestinal (stomach or intestine)
- Genitourinary problem
- Ears, nose, mouth or throat problem
- Hematologic (Blood)/ Lymphatic problem
- Immunologic problem
- Integumentary (skin) problem
- Musculoskeletal (muscle or joint) problem
- Neurological (nerve) problem
- Psychiatric problem
- Respiratory problem
- Tobacco use
- Alcohol use

Eye drops or drugs taken internally (including non-RX) or provide a list:

Name _____ for _____ How long? _____

Name _____ for _____ How long? _____

Name _____ for _____ How long? _____

Glasses worn: At all times For near only For distance only After contacts

Contacts worn: Regular soft Disposable soft Gas permeable hard
special: Monovision Bifocal Toric (astigmatism) soft

Last eye exam was _____ **year(s) ago by** _____ **City:** _____

Primary Health Care Physician: _____ **City:** _____