Concord Eye Care Center OD PA
Sonnie Bryant, O.D.

PATIENT NAME: _____ DOB: _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? ARE YOU HAVING ANY VISION PROBLEMS? PLEASE DECRIBE YOUR CURRENT VISION PROBLEMS? _____

_____

I CURRENTLY WEAR: (PLEASE CIRCLE ALL THAT APPLY) GLASSES CONTACTS NONE

IF YOU ARE CURRENTLY WEARING CONTACTS, WHAT TYPE? _____

WHAT SOLUTION? _____ DO YOU SLEEP IN THEM? YES NO HOW OFTEN? _____

REPLACEMENT SCHEDULE?(CIRCLE) DAILY TWO-WEEK MONTHLY QUARTERLY YEARLY

ARE YOU INTERESTED IN TRYING CONTACT LENS? YES NO

MEDICAL INFORMATION:

PRIMARY CARE PHYSICIAN: _____ LOCATION: _____

CURRENT MEDICATIONS: YES NO IF YES PLEASE LIST (INCLUDE OVER THE COUNTER, HERB, VITAMINS, AND BIRTH CONTROL): _____

_____

_____

MEDICATION ALLERGIES: YES NO IF YES PLEASE LIST: _____

DO YOU USE TOBACCO PRODUCTS? YES NO ALCOHOL? YES NO RECREATIONAL DRUGS: YES NO

IF YES, WHAT TYPE? FREQUENCY? HOW LONG? _____

DO YOU HAVE ANY OF THESE MEDICAL CONDITIONS? PLEASE MARK YES OR NO

MEDICAL CONDITION:	YES	NO		YES	NO
DIABETES			HEADACHES/MIGRANES		
HIGH BLOOD PRESSURE			PREGNANT/BREAST FEEDING		
HIGH CHOLESTEROL			THYROID DISEASE		
CANCER			AUTOIMMUNE		

PLEASE LIST ANY OTHER EYE CONDITIONS THAT YOU HAVE: _____

_____

DO YOU OR ANY OF YOUR BLOOD RELATIVES (I. E. PARENTS, GRANDPARENTS, BROTHER OR SISTER) HAVE ANY OF THESE OCULAR CONDITIONS? (PLEASE MARK WHO IT APPLIES TO)

OCULAR CONDITION:	SELF	RELATIVE	NO		SELF	RELATIVE	NO
MACULAR DEGENERATION				TURNED/CROSS EYES			
GLAUCOMA				DRY EYES/ALLERGIES			
CATARACTS				LAZY EYE			
BLINDNESS				RETINAL DETACHMENT			
EYE SURGERY				EYE INJURY			