



Primary Eye Care-Delano  
 1045 Crossing Drive, Ste 200  
 Delano, MN 55328  
 763-777-9393  
 Fax: 763-777-9358

Primary EyeCare-Hutchinson  
 1059 Hwy 15 S.  
 Hutchinson, MN 55350  
 320-587-4744  
 Fax: 320-587-9168

Primary EyeCare-Litchfield  
 520 Hwy 12 E., Ste 106  
 Litchfield, MN 55355  
 320-693-9333  
 Fax: 320-593-0520

Date: \_\_\_/\_\_\_/\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

M or F Occupation: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Hobbies: (Please circle) Golf, Boating/Fishing, Biking/Motorcycle, Tennis, Running, Gaming, Shooting/Hunting, Musical Instrument, Other \_\_\_\_\_

Last Eye Exam Date/Location: \_\_\_\_\_ Primary Care Physician/Location \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

What is the **Main Reason** for your visit today? \_\_\_\_\_

Do you have any other visual/ocular symptoms? \_\_\_\_\_

<b>Do you have any of these problems currently below?</b>		Do you wear glasses?	<b>Y / N</b>	
Blurred Vision <b>without</b> Glasses/Contacts	<b>Y / N</b>	How often do you wear your glasses?	<b>Full-time</b>	<b>Part-time</b>
Blurred Vision <b>with</b> Glasses/Contacts	<b>Y / N</b>			
Flashes/Floaters in vision	<b>Y / N</b>	Do you currently wear Contact Lenses?	<b>Y / N</b>	
Loss of side vision	<b>Y / N</b>	What brand do you wear (if known)?		
Double vision	<b>Y / N</b>	Are you interested in trying a different type of contact lens?	<b>Y / N</b>	
Eye pain or soreness	<b>Y / N</b>			
Dryness/grittiness/scratchiness	<b>Y / N</b>	If not wearing Contacts, any interest?	<b>Y / N</b>	
Excessive watering	<b>Y / N</b>			
Burning	<b>Y / N</b>	How much time do you spend outdoors per day?	hrs	
Eye fatigue/Tired eyes	<b>Y / N</b>			
		Do you have prescription sunglasses?	<b>Y / N</b>	
		Are you interested in Refractive Surgery (Laser or Cataract)?	<b>Y / N</b>	

**Personal Medical History (Review of Systems): Please check any of the following APPLIES to you, and list any medications for each condition that you check. IF YOU HAVE NONE OF THESE CONDITIONS PLEASE CHECK NONE.**

<b>Cardiovascular:</b> ___ None ___ Hypertension ___ Cholesterol ___ Stroke ___ Heart Disease ___ Other:	<b>Endocrine:</b> ___ None ___ Non-Insulin Dependent Diabetes ___ Insulin Dependent Diabetes ___ Thyroid Problem ___ Hormonal Dysfunction ___ Other:	<b>Respiratory:</b> ___ None ___ Asthma ___ Bronchitis ___ Emphysema ___ COPD ___ Other:
<b>Constitutional:</b> ___ None ___ Cancer ___ Trauma/Large Volume Blood Loss ___ Developmental Disability ___ Other:	<b>Ocular:</b> ___ None ___ Glaucoma ___ Macular Degeneration ___ Detached Retina ___ Crossed Eye/Lazy Eye ___ Other:	<b>Psychiatric:</b> ___ None ___ ADHD ___ Depression ___ Schizophrenia ___ Other:
<b>Neurological:</b> ___ None ___ Multiple Sclerosis ___ Epilepsy ___ Cerebral Palsy ___ Tumor ___ Other:	<b>Musculoskeletal:</b> ___ None ___ Osteoarthritis ___ Fibromyalgia ___ Muscular Dystrophy ___ Ankylosing Spondylitis ___ Other:	<b>Immunologic:</b> ___ None ___ AIDS or HIV ___ Rheumatoid Arthritis ___ Lupus ___ Other:
<b>Hematological:</b> ___ None ___ Anemia ___ Leukemia ___ Other:	<b>Gastrointestinal:</b> ___ None ___ Crohn's ___ Colitis ___ Other:	<b>Ear/Nose/Throat:</b> ___ None ___ Hearing Loss ___ Upper Respiratory Infection ___ Other:
<b>Dermatologic:</b> ___ None ___ Eczema ___ Rosacea ___ Psoriasis ___ Other:	<b>Allergies (please list)</b> ___ None Drug:  Environmental:	<b>Alcohol Use:</b> Y N amount:  <b>Tobacco Use</b> Y N amount:

**Please list any Medications and/or Drugs that you are taking (including herbal):**                    or    **See Attached List** \_\_\_\_\_

_____	For _____	_____	For _____
_____	For _____	_____	For _____
_____	For _____	_____	For _____
_____	For _____	_____	For _____
_____	For _____	_____	For _____

**Women: Are you Pregnant or Nursing currently? Y or N**

**Family History: Has anyone in your family (grandparents, parents, siblings, children) been diagnosed with:**

<u>Disease / Condition</u>	<u>Y</u>	<u>N</u>	<u>WHO</u>	<u>Disease / Condition</u>	<u>Y</u>	<u>N</u>	<u>WHO</u>
Retinal Detachment	Y	N	_____	Glaucoma	Y	N	_____
Blindness	Y	N	_____	Cataracts	Y	N	_____
Macular Degeneration	Y	N	_____	Diabetes	Y	N	_____
Crossed Eyes	Y	N	_____	Other Eye Problem			_____

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Minor/Age 17 or less, Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_

History Reviewed. Additions as noted above.