Primary EyeCare

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? _____

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

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.

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

Disease / Condition			**WHO**	**Disease / Condition**			**WHO**
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.