KIRKWOOD
EYE ASSOCIATES

Andrew J. Biondo, O.D.

Welcome Back!

We are pleased to welcome you back to our practice.

The following information will aid your doctor in providing the most complete care possible.
Please take a few minutes to fill out this form as completely as you can. If you have questions, we will be glad to assist you.

PATIENT INFORMATION

Name ____________________________________ Age _____ Birth date ___________Date _____________

Occupation / Employer _______________________ Grade / School _________________________________

Address Change? ____

Phone_ (Home) __________________ Phone (Work) _________________ Phone (Cell)__________________

REASON FOR YOUR VISIT

Please place a "√" in any ❒ that applies to today's visit.

- ❒ Annual Check-up / Not Having Any Problems
- ❒ Want Stronger Prescription for Distance Tasks
- ❒ Want Stronger Prescription for Near Tasks
- ❒ Want Bifocals or Reading Spectacles
- ❒ Replace Lost or Broken Spectacles
- ❒ Need Second Pair Spectacles or Sunglasses
- ❒ Need More Contact Lenses
- ❒ Would Like to Try Contact Lenses
- ❒ Need Reading Glasses Over Contact Lenses
- ❒ Trouble Using Eyes Comfortably
- ❒ Other ______________________________

Do you wear glasses? ❒ No ❒ Yes

❒ All the time ❒ Occasionally

❒ For distance tasks ❒ For near tasks ❒ Computer

Do you wear contact lenses? ❒ No ❒ Yes Type ______

Replacement Schedule __________ Hours Worn /Day _

Pairs Left ____ Solutions used ____________________

To get a better sense of how you use your eyes, are there any hobb participate in on a regular basis?

____

HEALTH HISTORY

EYE / VISION CONCERNS

Please place a "√" in any ❒ to indicate if you are experiencing any of the following.

- ❒ Blurred Vision – Distance
- ❒ Blurred Vision – Near
- ❒ Burning Eyes

Date of your last physical _______________

Members	Yourself	Family
Anemia	❒	❒
Arthritis	❒	❒
Asthma	❒	❒
Brain Tumor	❒	❒

Please place a "√" in any ❒ to indicate if you or any blood relative has had any of the following problems (including parents, grandparents, uncle, aunts, or siblings).

Members	Yourself	Family
HIV / AIDS	❒	❒
Kidney Disease	❒	❒
Lupus	❒	❒

❐ Crossed Eyes
❐ Crusty Eyelids
❐ Double Vision
❐ Dry Eyes
❐ Eye Infection / Injury
❐ Eye Pain
❐ Eye Strain
❐ Floaters or Spots
❐ Fluctuating Vision
❐ Itching Eyes
❐ Light Sensitivity
❐ Poor Night Vision
❐ Red Eyes
❐ Seeing Flashes or Halos
❐ Styes
❐ Temporary Loss of Vision
❐ Twitching Eyelid
❐ Watery Eyes

Cancer ❐ ❐
Cataracts ❐ ❐
Chemical Dependency ❐ ❐
Depression / Anxiety ❐ ❐
Diabetes ❐ ❐
Emphysema ❐ ❐
Epilepsy ❐ ❐
Glaucoma ❐ ❐
Headaches ❐ ❐
Head Injury ❐ ❐
Heart Condition / or Pacemaker ❐ ❐
Hepatitis (Type ______) ❐
Herpes ❐ ❐
High Blood Pressure ❐ ❐
High Cholesterol ❐ ❐

Macular Degeneration ❐
Multiple Sclerosis ❐ ❐
Myasthenia Gravis ❐ ❐
Pacemaker ❐ ❐
Sickle Cell or Trait ❐ ❐
Shingles ❐ ❐
Skin Disorder ❐ ❐
Stroke ❐ ❐
Thyroid Condition ❐ ❐
Ulcers ❐ ❐
Other ______________________________

Are you pregnant? ❐ Yes ❐ No Number of children ______________________

Do you use tobacco? ❐ Yes ❐ No

Do you use alcohol? ❐ Yes ❐ No

ALLERGIES / SENSITIVITIES

Please place a "√" in any ❐ to indicate if you have any allergies or sensitivities in the categories below.

❐ Drugs (Please List) ____

❐ Foods (Please List) ____

❐ Seasonal / Environmental (Please include which season bothers you most) ______________________________

MEDICATIONS / VITAMINS / SUPPLEMENTS

Please place a "√" in any ❐ to indicate if you use any prescribed or over-the-counter substances in the categories below.

❐ Medications (Please List) ____

❐ Vitamins / Supplements (Please List) ____

❐ Eye Drops (Please List) ____

– Thank You –