Chart#_____ **CHARLES F. GARONE, O.D.**

WELCOME TO OUR OFFICE Date:_____

NAME:_____ AGE: _____ DATE OF BIRTH: _____

ADDRESS:_____City_____ST_____Zip_____

Best Telephone number to reach you: Home Work Cell? ***(circle one)*** _____ E-mail:_____

If we cannot reach you by telephone **MAY** we: Leave **voicemail**? Y N Send a **TEXT** message? Y N Send you an **E-MAIL**? Y N

Occupation: _____ Social Security #: _____Hobbies:_____

How were you referred to our office?_____Approximate Date of Last Eye Exam:_____

WHAT BRINGS YOU INTO THE OFFICE TODAY? (Please check all that apply)

Routine Eye Exam and Check-Up? _____ Contact Lens Exam? _____ Medical Eye Problem? _____ Other?(explain)_____

PLEASE NOTE: Contact lenses are medical devices that can cause serious consequences, such as infection, inflammation, permanent damage and loss of vision if not fit and taken care of properly. Examining a contact lens patient takes additional time and expertise. For that reason, there are separate, additional charges for contact lens examinations that patients without contact lenses do not pay. These fees are due at the time of service.

1: Do you spend a lot of time on your smart phone or computer? **YES_____ NO_____** **(Scale of 1 being poor and 10 being excellent)**

2: Are your contacts as comfortable at the end of the day as they are at the beginning? **YES_____ NO_____** **Scale of 1-10 comfort of contact lenses when put in_____**

3. Do you take your contact lenses out earlier than you would like? **YES_____ NO_____** **Scale of 1-10 comfort of lenses when take out_____**

Do you have any of the following symptoms or eye diseases: (check all that apply)

Sensitivity to bright light ____ Blurred Vision ____ Double Vision ____ Redness in Eyes ____ Tired Eyes _____ Burning _____ Spots or Floaters _____

Flashing Lights _____ Eyelid Problems _____ Watering / Tearing of Eyes _____ Eye Pain with eye movement _____ Side Vision Loss _____

Headaches_____ Migraine Headaches_____ Cataracts_____ Macular Degeneration_____ Retinal Detachment_____ Lazy Eye _____

Have you ever had any eye injury or eye surgery?_____

What eye drops do you use every day?_____

How many hours a day do you spend using a computer?: Laptop_____ Desktop_____Nook_____ Cell Phone_____ What color eyes do you have?_____

REVIEW OF FAMILY HISTORY: Does anyone in your family have any serious eye disease such as **glaucoma** Y N **macular degeneration** Y N

retinal detachment Y N Do you have a family history of **diabetes** Y N or **high blood pressure** Y N

REVIEW OF YOUR GENERAL MEDICAL HISTORY: **Name of Primary / Family Dr._____ Phone#_____**

Medical Conditions that you are currently being treated for or have symptoms of: (please Mark or Circle all that apply)

Environmental Allergies Food Allergies Hearing Loss

Thyroid Diabetes Breast Cancer Hormone Replacement Therapy

Heart Issues High Blood Pressure High Cholesterol CardioVascular Accident (Stroke)

Lung Cancer Asthma Chronic Obstructive Pulmanry Disease (COPD)

Irritable Bowel Syndrome (IBS) Acid Reflux

Kidney Problems Bladder Issues Urinary Tract Infection (UTI)

Headaches Epilepsy Altzheimers Parkinsons Disease

Skin Cancer Roseacea Acne

HIV Positive AIDS Leukemia

Arthritis Joint Pain Osteoporosis

Depression Anxiety ADD ADHD

OTHER_____

What Medications do you take every day?_____

_____

Drug or Medication allergies / sensitivities?_____

(Female patients Only) Are you pregnant **OR** trying to become pregnant? Yes_____ No_____

REVIEW OF SOCIAL HISTORY: Do you use Tobacco? Yes _____ No _____ Alcohol? Yes _____ No _____ Other Substances? Yes _____ No _____

PATIENT SIGNATURE: _____ DATE: _____