

# ***NORMAN A. ROSE, O.D. INC.***

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[www.drnormanrose.com](http://www.drnormanrose.com)

## **WELCOME TO OUR OFFICE**

Our office is dedicated to servicing our patients with the highest quality of vision care. We use continuing educating to remain at the forefront of our profession and offer the latest eye care technology, professional services and products, we believe that our patients are our friends and that our relationship can last a lifetime.

### **ADULT HISTORY QUESTIONNAIRE**

**Please fill out this form carefully and return it one week before your appointment.**

Today's Date: \_\_\_\_\_ Home Phone: (    ) \_\_\_\_\_

Work Phone: (    ) \_\_\_\_\_ Cell Phone: (    ) \_\_\_\_\_

Mr.     Mrs.     Miss     Ms                      Email Address \_\_\_\_\_

Patient's Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Birthday: \_\_\_\_\_

Siblings \_\_\_\_\_

Patient's Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Primary Medical Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Vision Insurance: \_\_\_\_\_ ID# \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Insured's Name (if different form patient) \_\_\_\_\_ ID# \_\_\_\_\_

Insured's Birthday: \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Social Security # \_\_\_\_\_ Driver's License # \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Friend     Doctor     Relative     School     Yellow Pages     Other \_\_\_\_\_

**MEDICAL HISTORY**

Do you have any allergies to medications?  No  Yes If yes, explain: \_\_\_\_\_

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List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

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List all major or injuries, surgeries and / or hospitalizations you have had: \_\_\_\_\_

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List any of the following that you have had: crossed eyes, lazy eye, dropping eyelid, prominent eyes, glaucoma, retinal disease, cataracts, eye infections or eye injury: \_\_\_\_\_

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Are you pregnant and / or nursing?  No  Yes

Do you wear glasses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Do you wear contact lenses?  No  Yes If yes, how old is your present pair of lenses? \_\_\_\_\_

Type of contact lenses:  Rigid  Soft  Extended Wear  Other Are they comfortable?  Yes  No \_\_\_\_\_

**FAMILY HISTORY**

Please note any family history (parent, grandparent, siblings, children; living or deceased) for the following condition:

DISEASE / CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Blindness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cataract	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Crossed Eye	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Amblyopic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Glaucoma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Macular Degeneration	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Retinal Detachment / Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Heart Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Kidney Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Lupus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Thyroid Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

**VISUAL HISTORY**

Have you had a previous vision evaluation? Yes  No

If yes, doctor's name: \_\_\_\_\_

Date of last evaluation: \_\_\_\_\_

Reason for examination: \_\_\_\_\_

Were glasses, contact lenses or other optical devices recommended? Yes  No

If yes, what? \_\_\_\_\_

Are they used? Yes  NO  If yes, when? \_\_\_\_\_

Were any additional tests, treatments, or therapies recommended concerning your vision?

Yes  No  If yes, what? \_\_\_\_\_

Did you undergo these treatments? Yes  NO  Explain: \_\_\_\_\_

Results and recommendations: \_\_\_\_\_

**SOCIAL HISTORY:**

Do you use tobacco products?  NO  YES If yes, type / amount/ how long: \_\_\_\_\_

Do you drink alcohol?  NO  YES If yes, type / amount/ how long: \_\_\_\_\_

Do you use illegal drugs?  NO  YES If yes, type / amount/ how long: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Do you currently, or have you ever had any problems in the following areas:

<b>SYSTEM</b>	<b>NO</b>	<b>YES</b>	<b>?</b>		<b>NO</b>	<b>YES</b>	<b>?</b>
<b>CONSTITUTIONAL</b>							
Fever, Weight Loss / Gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>INTEGUMENTARY (Skin)</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>NEUROLOGICAL</b>							
Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Seizures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>EYES</b>							
Loss of vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Blurred Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Distorted Vision / Halos	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Loss of Side Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Double Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Dryness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Mucous Discharge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Redness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Sandy or Gritty Feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Itching	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Burning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Foreign Body Sensation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Excess Tearing/ Watering	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Glare / Light Sensitivity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Eye Pain or Soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Chronic Infection of Eye or Lid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Sties or Chalazion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Flashes / Floaters in Vision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
Tired Eyes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
<b>ENDOCRINE</b>							
Thyroid / Other Glands	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>				
				<b>EARS, NOSE, MOUTH THROAT</b>			
				Allergies / Hay Fever	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Sinus Congestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Runny Nose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Post-Nasal Drip	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Dry Throat / Mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>RESPIRATORY</b>			
				Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Chronic Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>VASCULAR / CARDIOVASCULAR</b>			
				Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Heart Pain			
				High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Vascular Disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>GASTROINTESTINAL</b>			
				Diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Constipation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>GENITOURINARY</b>			
				Genitals / Kidney / Bladder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>BONES / JOINTS / MUSCLES</b>			
				Rheumatoid Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Muscle Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Joint Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>LYMPHATIC / HEMATOLOGIC</b>			
				Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				Bleeding Problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>ALLERGIC / IMMUNOLOGIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
				<b>PSYCHIATRIC</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you answered YES to any of the above or have a condition not listed, please explain & list medications:

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## Patient Questionnaire for Vision Problem

Name: \_\_\_\_\_

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

Do you suffer from any of the following signs or symptoms of a potential vision problem?

**Please Score as Follows: ( 0 Never / 1 Seldom / 2 Occasionally / 3 Often / 4 Always )**

<u>Physical Signs</u>	Score
Do you:	
Notice that distance objects look blurry?	
Have headaches while doing close work or when working on the computer?	
Blink excessively or rub your eyes?	
Hold books extremely close ?	
Cover one eye by leaning on your hand?	
Fall asleep when reading?	
Notice that words run together when reading?	
<u>Performance Problems</u>	Score
Do you:	
Have trouble copying work from a distance?	
Avoid reading?	
Lose your place when reading?	
Skip or repeat words and lines?	
Have difficulty completing work in a reasonable time?	
Tend toward clumsiness?	
Reverse letters and numbers?	
<u>Secondary Symptoms</u>	Score
Do you:	
Have a short attention span ?	
Have poor self-esteem and confidence at work?	
Do you procrastinate when work needs to be done?	
Have frustration and anxiety associated with work?	
Seem to perform below your potential?	
Total scores above 20 or any one question above "3" raises suspicion about a potential vision problem.	<b>Total</b>

**PRESENT SITUATION**

Describe any indications of visual difficulty: \_\_\_\_\_  
\_\_\_\_\_

Do you feel your vision hinders your daily activities in any way? If so, how? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ understand that I/MY dependents are eligible for \_\_\_\_\_  
Insurance through MY/SPOUSE'S Employment. I am aware that if the above is not true, I or the person financially  
responsible for me, are responsible for all charges related to services provide to me. I agree that if the above is not true, I or  
the person financially responsible will pay in full for all such charges.

\_\_\_\_\_  
Signature



