Neil W. Draisin, O.D., FCOVD
Jennifer M. Smith, O.D.
Michael W. Zolman, O.D.
1470 Tobais Gadson Blvd., Ste. 115
Charleston, SC 29407
T: 843-556-20/20 F: 843-763-3937
www.draisinvision.com

Please complete this form to the best of your knowledge and bring it with you to your appointment.

A. GENERAL PATIENT INFORMATION

Full Name _____ Social Security Number _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Date of Birth _____ Marital Status: o Single o Married o Divorced o Separated o Widowed
Employer _____ Occupation _____
Business address _____ City _____ State _____ Zip _____
Business Phone _____
Spouse Employer _____ Occupation _____
Nearest living relative _____ Phone _____

Major Medical Insurance Company _____
Policy Number _____
Who may we thank for referring you to our office?_____

B. MEDICAL HISTORY

Most recent medical examination: _____
Doctor's Name Date

_____
Results

Current diet – Nutritionally: o Excellent o Good o Fair o Poor

Personal & Family Medical History

Allergies	o Self o Family	Glaucoma	o Self o Family
Asthma	o Self o Family	Eye disease	o Self o Family
Arthritis	o Self o Family	Heart disease	o Self o Family
High Blood Pres	o Self o Family	Eye injury	o Self o Family
Eye surgery	o Self o Family	Cancer	o Self o Family
Diabetes	o Self o Family	Cataract	o Self o Family
Thyroid Condition	o Self o Family	Blindness	o Self o Family
_____	o Self o Family	_____	o Self o Family

Current Medications (Rx & Over the Counter)

Name of Medications

Antihistamines	o No o Yes	_____
Diuretics (water pills)	o No o Yes	_____
Blood Pressure Pills	o No o Yes	_____
Oral contraceptives	o No o Yes	_____
Sleeping tablets	o No o Yes	_____
Eye drops	o No o Yes	_____

Other _____

Are you currently under the care of a physician? O No O Yes

Name of physician _____

C. **VISUAL HISTORY**

Previous examinations: _____
Doctor's Name Date

Reason for examination: _____

Results: _____

Do you wear glasses? O No O Yes
How often do you wear them? _____ How long have you had them? _____

Members of the family who have had visual attention and why:

NAME	AGE	VISUAL SITUATION

D. **PRESENT SITUATION**

Describe any indications of visual difficulty: _____
_____
_____

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

Please mark any of the following that apply:

O Eyes itch, burn, tear, red at distance or near.
O Periodic or constant double vision at near or distance
O Omission of words when reading or copying material
O Covering or closing one eye
O Skipping lines when reading
O Repetition of letters in words; difficulty aligning columns of numbers
O Headaches or nausea with near tasks
O Lack of comprehension when reading
O Short attention span when performing visual tasks
O Letters, words, or both appear to float around
O Excessive head movement when reading
O Frequent loss or copying material
O Confusion of what is being seen or read
O Close working distance at near
O Use finger or marker to keep place when reading
O Head tilt
O Postural changes when doing desk work
O General or visual fatigue at end of the day
O Difficulty sustaining near point work such as reading or writing
O Blur at distance or near after reading

Comments on any above checked items: _____
_____
_____
_____

E. **EMPLOYMENT OR SCHOOL**

Current position _____ Major Course of Study _____
How many hours daily do you spend:
At a desk? _____ Reading or studying? _____ Working at near distances? _____

Are you achieving to your potential in work or school? o No o Yes

Do you feel you are getting adequate return for the amount of effort you put into a task? _____

Does your work or course of study demand comprehension? o No o Yes

F. **AVOCATIONS**

Describe what activities comprise the majority of your spare time. _____
_____
_____
_____

Do you watch T.V.? o No o Yes How long per day and days per week? _____

Viewing distance _____

Are you seriously involved in athletics? o No o Yes

Do you feel you are achieving up to your potential? o No o Yes

Out of all the sports you have played:
List the ones you excel in _____
List the ones you do poorly in _____

Thank you for completing this form.

The information supplied will permit us to make a complete optometric evaluation of your visual system related to your specific needs.