

Papale & Bouvier Eye Center

Today's Date: _____

| | | | | |
|---|--------|--|-------------------|-------------|
| First Name: | | Age: | Gender: M F | |
| Last Name: | | DOB: | Home Phone: | |
| Address: | | | Work Phone: | |
| City: | State: | Zip: | Cell Phone: | |
| Employer: | | Occupation: | E-mail Address: | |
| Are you pregnant or nursing? Y/N | | Do you take: Acutane Y/N | Cordorone Y/N | Imitrex Y/N |
| Are you allergic to any medications? Y/N _____ | | WHERE DID YOU LEARN ABOUT US? <i>PLEASE CIRCLE ALL THAT APPLY</i> TV Channel 22 TV Channel 40 Other TV website Radio (am) 560, 640 Radio (fm) 93.1, 94.7, 97.9 100.9 102, Other patient _____ Optometrist _____ Other doctor _____ Other _____ | | |
| Are you being treated for any medical condition? _____ | | | | |
| List any medications you take (including oral contraceptives and over the counter): | | | | |

Have you ever had or been told that you have:

| General Eye Conditions | Yes | No | General Health Conditions | Yes | No |
|----------------------------|-----|----|---------------------------|-----|----|
| Glaucoma | | | Diabetes | | |
| Cataracts | | | High Blood Pressure | | |
| Retinal Detachment/Disease | | | Heart Disease | | |
| Lazy Eye/Amblyopia | | | Breathing Problems | | |
| Eye Surgery | | | Auto-Immune Disease | | |
| Dry Eye | | | Arthritis | | |
| Keratoconus | | | Collagen-Vascular Disease | | |
| Blepharitis | | | Endocrine/ Thyroid | | |
| Macular Degeneration | | | Keloids | | |
| Other: | | | Other: | | |

VISION:

V: CC

V: SC

W:

AGE OF WEAR:

AR:

AK:

Pachymetry

Pupil: Dim Bright

Reading glasses discussed? YES NO

OD

OS

OD

OS

Recommendations:

At The Papale and Bouvier Eye Center, we strive to provide the best quality of care and customized vision solutions for our patients. This checklist will assist us in providing the treatment best suited for your visual needs & lifestyle. Please fill this form out completely and return it to us.

| | | | | |
|--|--------------------------------|---------------------------------|-----------------------------------|---------------------------------|
| How often do you have these eye problems: | | | | |
| Redness | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Sandy/Gritty feeling | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Itching | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Excess Watering | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Burning | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Excess Mucus | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Blurry Vision (helped by blinking) | | | | |
| How often are your eyes sensitive to these conditions: | | | | |
| Smoke | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Light | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Wind | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Computer Screens | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Heaters | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Air Conditioning | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |
| Contact lenses | <input type="checkbox"/> Never | <input type="checkbox"/> Rarely | <input type="checkbox"/> Commonly | <input type="checkbox"/> Always |

- When was your last eye exam? _____
Eye Doctor's name/ City _____
- Do you wear contact lenses? Yes No What type? _____
How many hours a day do you wear them? _____
At what age did you start wearing them? _____
When did you last wear them? _____
- What are some of your daily work related tasks? _____
- What are your hobbies? _____
- How would you describe your personality? Easy going Perfectionist
- Is it acceptable to you that you may need glasses for reading after laser vision correction? Yes No
- How long have you considered laser vision correction? _____
- Have you had any other screenings? Yes No
If yes, with which doctors/ centers? _____
- How soon would you like to have surgery? _____

RECORDS RELEASE AUTHORIZATION

Date: ____/____/____

To Dr: _____

I hereby authorize you to release my complete medical record to:

**Papale & Bouvier Eye Center
1515 Allen Street, Suite E
Springfield, MA 01118**

Patient Name: _____

Address: _____

Signature: _____