# Dr. Thomas D. Tomasik & Dr. Ashley Jadene Stevens

Please complete the following confidential information. This information is extremely important for proper treatment. If you would like assistance in completing this form, our staff will be happy to assist you.

Legal Name _____Exam Date _____ OM# _____

Mailing Address _____Date of Birth _____

Home Phone _____ Day Phone _____ Ext. _____ Cell Phone_____

Gender: M / F Marital Status: M S W D Significant other _____ **Referred By** _____

Occupation/ Employer or School_____

Financially Responsible Party _____ If Child, Parent/ Guardian Name _____

Address ( If Different ) _____ E-mail _____

Primary Care Physician _____ Vision Insurance _____ Medical Insurance _____

Last Eye Exam _____ Last Physical Exam _____

**Reason for Exam** (Please circle) Routine - Cataract – Diabetes - Contact Lenses - Refractive Surgery

**Are you having problems with: (Please check, if yes, please note which eye)**

| | | | | |
|---|---|---|---|---|
| ___ Blurred Vision | ___ Eye Injury | ___ Mucous Discharge | ___ Itching | ___ Burning |
| ___ Changes in Vision | ___ Flashes | ___ Eye Pain | ___ Tearing | ___ Loss of Vision |
| ___ Difficulty Driving | ___ Floaters | ___ Dryness | ___ Glare | ___ Loss of Side Vision |
| ___ Difficulty Reading | ___ Lid Swelling | ___ Redness | ___ Headaches | ___ Fluctuating Vision |
| ___ Double Vision | ___ Halos | ___ Soreness | ___ Migraines | ___ Other _____ |

**Eye History: (Please check, if yes, please note which eye and how long or when)**

| | | |
|---|---|---|
| ___ Amblyopia / Lazy Eye R / L | ___ Glaucoma R / L | **Eye Surgery: (Doctor and Approx. Date)** |
| ___ Strabismus/ Eye Turn R / L | ___ Macular Degeneration R / L | ___ Cataracts R / L by Dr. _____ |
| ___ Blindness R / L | ___ Retinal Problems R / L | ___ Glaucoma R / L by Dr. _____ |
| ___ Color Blindness | ___ Eye Injury R / L | ___ Retinal Surgery R / L by Dr. _____ |
| ___ Cataracts R / L | ___ Corneal Problem R / L | ___ Laser Surgery R / L by Dr. _____ |

**Social History:**

___ Tobacco use Y / N ___ Alcohol use Y / N

**Medical History:**

| | | | |
|---|---|---|---|
| ___ Diabetes - Since _____ | ___ Respiratory | ___ Neurological | ___ Blood disorders |
| ___ Hypertension - Since _____ | ___ Gastrointestinal | ___ Endocrine | ___ Skin/ breasts |
| ___ Cardiovascular (heart, cholesterol) | ___ Musculoskeletal | ___ Psychiatric | ___Constitutional |
| ___ Ears, nose, throat | ___ Genitourinary | | |

___ Allergies (Please list all, including specific medications)_____

_____

Please list all medications you are currently taking: _____

_____

**Are you currently using any eye drops:** Yes / No If so, please list them _____

**Family Medical and Ocular History: (Please circle)**

| | | | | |
|---|---|---|---|---|
| Diabetes | Heart Disease | Glaucoma | Color Blindness | Retinal Problems |
| Hypertension | Cancer | Cataract | Corneal Problems | Other _____ |

**No changes in my ocular or medical history or medications since _____. Initial_____ Date _____**