NORTHPOINT
Eye Studio

ABOUT YOU

Full Name ○ Mr. ○ Mrs. ○ Miss. ○ Ms. ○ Dr. ○ Prof. _____ Gender ○ M ○ F

Nickname _____ DOB ___/___/___ Phone Number: _____

Email Address: _____ Primary Address: _____

_____

- ☐ American Indian/Alaskan Native
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic or Latino
- ☐ Native Hawaiian/Pacific Islander
- ☐ Other
- ☐ Decline

Do you use **tobacco** products?
- ☐ Y → Type _____ Frequency _____
- ☐ N
- ☐ Not anymore

Do you drink **alcohol**?
- ☐ Y → ☐ Minimal ☐ Moderate ☐ Excessive
- ☐ N
- ☐ Not anymore

How did you hear about us? _____

WORK/HOBBIES

Occupation _____

Employer _____

Hours spent on computer per day:

- ☐ 0-3
- ☐ 3-6
- ☐ 6-9
- ☐ 9+

Special visual demands for work:
- ☐ Computer Lenses
- ☐ Safety Glasses
- ☐ Extra magnification
- ☐ Other _____

☐  Reading/ Writing

☐  Golf

☐  Swimming

☐  Cycling

☐  Fishing/ Boating

☐  Travel

☐  Knitting/ Sewing

☐  Motorcycles

VISION

	Y	N
Are you happy with your vision?	☐	☐
Do you currently/are you supposed to wear **glasses**?	☐	☐
Would you like to get new glasses this year?	☐	☐
Have you worn **contacts** before?	☐	☐
Are you interested in **contacts** this year?	☐	☐
Are you interested in **laser vision correction?**	☐	☐
Are you interested in **eliminating** the need for glasses or contact lenses **non-surgically?**	☐	☐

Please mark any symptoms you are experiencing:
- ☐ Blurred Vision
- ☐ Eyestrain
- ☐ Eye Pain
- ☐ Light Sensitivity
- ☐ Headache
- ☐ Poor Night Vision
- ☐ Night Glare
- ☐ Double Vision
- ☐ Loss of Side Vision
- ☐ Floaters
- ☐ Flashes of Light
- ☐ Total Loss of Vision

Other _____

EYE HEALTH

When was your last **eye exam?** _____ Doctor _____

When was your last **physical**? _____ Doctor _____

Please mark if you have ever been diagnosed with:
- ☐ Cataract
- ☐ Diabetic Retinopathy
- ☐ Dry Eye
- ☐ Eye Infection/Inflammation/Allergy
- ☐ Glaucoma
- ☐ Iritis or Uveitis
- ☐ Keratoconus/Other Corneal Disorder
- ☐ Macular Degeneration
- ☐ Nevus (Freckle) of the Eye
- ☐ Retinal Defects or Degenerations

Do you have any history of eye disease, injuries, or surgeries not listed above? If so, please list:

_____

_____

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YOUR HEALTH HISTORY

OVERALL HEALTH:
- ☐ No Health Problems
- ☐ Developmental Delays
- ☐ Cancer
- ☐ Fatigue Syndrome
- ☐ Other _____

EAR, NOSE AND THROAT:
- ☐ None
- ☐ Hearing Loss
- ☐ Sinusitis
- ☐ Dry Mouth
- ☐ Laryngitis
- ☐ Other _____

PSYCHIATRIC:
- ☐ None
- ☐ Depression
- ☐ Attention Deficit
- ☐ Anxiety Disorder
- ☐ Bipolar Disorder
- ☐ Other _____

CARDIOVASCULAR:
- ☐ None
- ☐ Hypertension
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Vascular Disease
- ☐ Congestive Heart Failure
- ☐ Other _____

HEMATOLOGIC/LYMPHATIC:
- ☐ None
- ☐ Anemia
- ☐ Large Volume Blood Loss
- ☐ Ulcer
- ☐ Hypercholesteremia
- ☐ Other _____

RESPIRATORY:
- ☐ None
- ☐ Cigarette Smoker
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Obstruction
- ☐ Sleep Apnea
- ☐ Other _____

GASTROINTESTINAL:
- ☐ None
- ☐ Crohn's
- ☐ Colitis
- ☐ Ulcer
- ☐ Acid Reflex
- ☐ Celiac Disease
- ☐ Other _____

GENITOURINARY:
- ☐ None
- ☐ Kidney Disease
- ☐ Prostate Disease/Cancer
- ☐ STD-Herpetic/Chlamydia
- ☐ Benign Prostate Hypertrophy
- ☐ Pregnant _____ weeks
- ☐ Nursing
- ☐ Other _____

MUSCULOSKELETAL:
- ☐ None
- ☐ Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Ankylosing Spondylitis
- ☐ Osteoporosis
- ☐ Gout
- ☐ Other _____

INTEGUMENTARY (*body's outer layer*):
- ☐ None
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ HSV/Cold Sores
- ☐ Herpes Zoster/Shingles
- ☐ Other _____

ALLERGIC/IMMUNE:
- ☐ None
- ☐ Drug Allergies
- ☐ Environmental Allergies
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Sjögren's Syndrome
- ☐ Other _____

NEUROLOGICAL:
- ☐ None
- ☐ MS
- ☐ Epilepsy
- ☐ Cerebral Palsy
- ☐ Tumor
- ☐ Stroke/CVA
- ☐ Migraine
- ☐ Other _____

ENDOCRINE:
- ☐ None
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes

  If diabetic, please list:

  Last A1C: _____

  Average BSL: _____
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Other _____

FAMILY HISTORY

☐ *Mark if family history is unknown. You may skip to the next page.*

Please mark any that apply:

	Mother	Father	Sibling	Child	Grandparent	Unsure
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Cataract	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Corneal Disease	☐	☐	☐	☐	☐	☐
Macular Degeneration	☐	☐	☐	☐	☐	☐
Retinal Detachment	☐	☐	☐	☐	☐	☐

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MEDICATIONS

For those on multiple medications, you are welcome to provide a list instead if you prefer.

Please list current medications: _____ And their purpose: _____

If you are taking any **eye vitamins**, please list: _____

Preferred Pharmacy _____ Pharmacy Location _____

Medication Allergies _____

Other Allergies _____

DRY EYE SCREENING

Please mark if you are experiencing any of the following **comfort issues:**

- ☐ Redness
- ☐ Itching
- ☐ Soreness/Irritation
- ☐ Dryness/Grittiness
- ☐ Burning
- ☐ Watering
- ☐ Discharge
- ☐ Pain

Rate the **severity** of each symptom: *0= None 1= Tolerable 2= Uncomfortable 3= Bothersome 4= Intolerable*

	0	1	2	3	4
Dryness/Grittiness	○	○	○	○	○
Soreness/Irritation	○	○	○	○	○
Burning	○	○	○	○	○
Watering	○	○	○	○	○
Eye Fatigue	○	○	○	○	○

Rate the **frequency** of each symptom: *0= Never 1= Sometimes 2= Often 3= Constantly*

	0	1	2	3
Dryness/Grittiness	○	○	○	○
Soreness/Irritation	○	○	○	○
Burning	○	○	○	○
Watering	○	○	○	○
Eye Fatigue	○	○	○	○

Have you been using any eye drops? ☐ Yes ☐ No → Name of drop: _____

How often do you use it? _____

Used within last 4 hours? ☐ Yes ☐ No