Today's Date: _____

PAPALE EYE CENTER

First Name:			Age:	Gender: M F
Last Name:			DOB:	Home Phone:
Address:			DOB: Ge	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 _____

Are you being treated for any medical condition? _____

List any medications you take (including oral contraceptives and over the counter):

WHERE DID YOU LEARN ABOUT US?

PLEASE CIRCLE ALL THAT APPLY

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 _____

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:**

AR: **AK:** **AGE OF WEAR:**

Pachymetry

OD **OS**

Pupil: Dim Bright

OD

OS

Reading glasses discussed? YES NO

Recommendations:

*=CK Consults

At The Papale 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	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Sandy/Gritty feeling	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Itching	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Excess Watering	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Burning	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Excess Mucus	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Blurry Vision (helped by blinking)				

How often are your eyes sensitive to these conditions:

Smoke	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Light	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Wind	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Computer Screens	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Heaters	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Air Conditioning	☐ Never	☐ Rarely	☐ Commonly	☐ Always
Contact lenses	☐ Never	☐ Rarely	☐ Commonly	☐ 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 Eye Dr: _____

_____

_____

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

Papale Eye Center
1515 Allen Street, Suite E
Springfield, MA 01118
Ph (413) 782-0030 Fax (413) 796-1985

Patient Name:_____

Address: _____

_____

_____

Signature: _____