Michael J. Rengert, O.D.
Amanda J. Delmore, O.D.
Bryan J. Delmore, O.D.
Lucy Pickering, O.D.

Name Mr / Mrs / Ms / Miss / Dr ______________________________ Date of Birth __________
Address ____
Telephone Home: ________________ Work:________________ Cell:______________
E-mail Address ____
Social Security # ____
Spouse's Name ____
Your Occupation ______________________Where Employed______________________
If you are a student, name of school/college ______________________________________
Children's names and ages ____
Whom may we thank for referring you? ____
Primary reason for today's visit ____
Do you have **vision** insurance you plan to use for today's visit? Yes No Provider? _____________
Do you have major **medical** insurance? Yes No Provider? ____________________________

PLEASE CIRCLE THE ANSWER TO THE FOLLOWING QUESTIONS:

Do you ever experience double vision? Yes No
Are you troubled by frequent headaches? Yes No
Associated with any particular activity? Yes No _________________________
Are you presently taking any medications? Yes No
If so, please list ____
Are you presently under a physician's care? Yes No
Physician's name _________________________
Do you have allergies or hay fever? Yes No
Do you wear UV protective sunglasses regularly? Yes No
Do you have particular difficulty driving at night? Yes No
Do you use a computer? Yes No

OPTICAL HISTORY:

Date of last eye exam _____________ Doctor ______________ Location ________________
Do you wear glasses? Yes No
If so, when? Constant Distance Near/Reading
If so, what is the age of your present glasses? __________________
Where did you purchase them? ____________________________
Are there times when you'd prefer not to wear glasses? Yes No
If so, when? ____
Are you interested in contact lenses? Yes No
Do you currently wear contact lenses? Yes No
If so, what type? Soft RGP Hard Disposable
Hours worn each day ______ What solutions do you use? _______________________
Do your eyes become dry, itchy, or irritated when wearing contact lenses? Yes No
Do your contact lenses become less comfortable as the day progresses? Yes No
Have you had laser or vision corrective surgery? Yes No
If so, when? ___________________ Doctor ________________________________
Are you interested in learning more about laser vision correction? Yes No

FAMILY HISTORY

PLEASE LIST BLOOD RELATIVES (parents, siblings, grandparents) with the following conditions:

Diabetes ______________________ / **Hypertension** ______________________ / **Cancer** ______________________

Cataracts ____________________ / **Macular Degeneration** ___________________ / **Glaucoma** __________________

Eye Surgery ____________________ / **Other Eye Problems**, please specify ___________________________________

PERSONAL EYE HISTORY

Have YOU had any of the following (circle)?: **Cataracts / Macular Degeneration / Glaucoma / Eye Surgery**
Retinal Detachment / Floaters or Flashes
Other Eye Problems: ____

Circle ONLY Current Health Conditions (otherwise leave blank)

Constitution		**Cardiovascular**		**Musculoskeletal**	
Fatigue Syndrome	Yes	Congestive Heart Failure	Yes	Arthritis	Yes
Cancer	Yes	Heart Disease	Yes	Ankylosing Spondylitis	Yes
Developmental Disabilities	Yes	Stroke/CVA	Yes	Fibromyalgia	Yes
Other	Yes	Hypertension/High B.P.	Yes	Gout	Yes
ENT		Other	Yes	Osteoporosis	Yes
Laryngitis	Yes	**Psychiatric**		Muscular Dystrophy	Yes
Hearing Loss	Yes	Depression	Yes	Osteoarthritis	Yes
Dry Mouth	Yes	Anxiety Disorder	Yes	Other	Yes
Sinusitis	Yes	Bipolar Disorder	Yes	**Integumentary/Skin**	
Other	Yes	Attention Deficit	Yes	Cold Sores	Yes
Neurological		Other	Yes	Eczema	Yes
Epilepsy	Yes	**Gastrointestinal**		Psoriasis	Yes
Tumor	Yes	Celiac Disease	Yes	Rosacea	Yes
Cerebral Palsy	Yes	Ulcer	Yes	Shingles	Yes
Migraine	Yes	Colitis	Yes	Other	Yes
Multiple Sclerosis	Yes	Acid Reflux	Yes	**Endocrine**	
Stroke/CVA	Yes	Crohn's Disease	Yes	Diabetes Type 1	Yes
Other	Yes	Other	Yes	Diabetes Type II	Yes
Respiratory		**Genitourinary**		Hormone Dysfunction	Yes
Asthma	Yes	Pregnant	Yes	Thyroid Dysfunction	Yes
Emphysema	Yes	Nursing	Yes	Other	Yes
Smoker	Yes	Kidney Disease	Yes	**Hematologic/Lymphatic**	
Chronic Obstruction	Yes	Prostate Disease/Cancer	Yes	Anemia	Yes
Bronchitis	Yes	Benign Prostate Hypertrophy	Yes	Large-Volume Blood Loss	Yes
Sleep Apnea	Yes	STD	Yes	High Cholesterol	Yes
Other	Yes	Other	Yes	Ulcer	Yes
				Other	Yes
				Allergy/Immunologic	
				Sjogren's Syndrome	Yes
				Rheumatoid Arthritis	Yes
				Lupus	Yes
				Drug Allergies	Yes
				Environmental Allergies	Yes
				Please list allergies:	

PLEASE CIRCLE ACTIVITIES YOU PARTICIPATE IN:

Painting	Music	Racquetball	Scuba diving
Ceramics	Stamp Collecting	Soccer	Fishing
Knitting	Coin Collecting	Golf	Model building
Sewing	Home Workshop	Football	Softball
Needlepoint	Reading	Swimming	Bowling
Electronic	Photography	Tennis	Lawn Care
Computer	Basketball	Hockey	
Public Speaking	Baseball	Skiing	

PAYMENT POLICY Examination fees are due at the time of service.

SIGNATURE ____________________________________ TODAY'S DATE__________________