Tonya Cannon Stewart, O.D.
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Welcome to Our Office

Patient's Name: _____ Birthdate _____ Age _____ Date _____

Title: ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. **Marital Status:** ❑ Single ❑ Married **Sex:** ❑ Male ❑ Female

Home Address_____ City: _____State: _____Zip: _____

Home Phone _____ Employer _____ Occupation _____

Business Address _____ Work Phone _____ Cell Phone _____

Do you have Medicare? ❑ Yes ❑ No Do you have Medicaid? ❑ Yes ❑ No

Do you have vision insurance? ❑ Yes ❑ No If yes, list _____

Have you been a patient of Dr. Robertson before? ❑ Yes ❑ No

How did you learn about our office? (Please circle) Newspaper Driving by Family Member Friend Other

Medical History: Check any conditions which apply to you

❑ AIDS/HIV	❑ Eye Disease	❑ Kidney Disease	❑ Cancer
❑ Arthritis	❑ Heart Condition	❑ Liver Disease	❑ Other_____
❑ Asthma/Lung disease	❑ Hepatitis Type_____	❑ Tuberculosis	
❑ Diabetes _____years	❑ High Blood Pressure	❑ Thyroid Disease	

List any medication you are taking and for what condition: _____

_____

Are you allergic to any medications? ❑ Yes ❑ No List: _____

Females: Are you pregnant? ❑ Yes ❑ No or Nursing? ❑ Yes ❑ No

Family History: Do any of your immediate family members have diabetes? ❑ Yes ❑ No

or Glaucoma? ❑ Yes ❑ No or other eye diseases or conditions? _____

Ocular History: Check any conditions or symptoms which apply to you

❑ Blindness	❑ Crossed Eyes	❑ Flashes of Light	❑ Lazy Eye/Amblyopia
❑ Blurred Vision	❑ Double Vision	❑ Floaters/Spots	❑ Seeing Halos
❑ Burning	❑ Eye Injury	❑ Glaucoma	❑ Watering
❑ Cataracts	❑ Eye Surgery	❑ Itching	❑ Other _____

Do you currently wear contacts? ❑ Yes ❑ No or have you worn them in the past? ❑ Yes ❑ No

Do you want to be examined for contacts today? ❑ Yes ❑ No

Social History: Check any job tasks or hobbies you perform

❑ Computer Work	❑ Reading	❑ Golf	❑ Team Sports
❑ Piano	❑ Sewing	❑ Tennis	❑ Studying

Pupil Dilation:

- Provides more thorough health exam of the eye
- Every 2-3 years if general health is good
- Every 6 months if diabetic, high blood pressure, highly near-sighted or previously noted eye disease
- Lasts about 4 hours - may experience poor depth perception, light sensitivity and blurred vision

❑ I ***DO*** want my eyes dilated today

❑ I ***DO NOT*** want dilation today and understand the limitations of an exam without dilation

Signature of Patient or Responsible Party _____