Lally Vision Care

Steven Lally, O.D. Tron Lally, O.D.

Name_____ **Date of Birth**_____/_____/_____

Your *Family* History

Please mark and state who of your *Parents, Grandparents or siblings* have any of the following: ☐ **N/A**

- ☐ Blindness_____
- ☐ Cataract_____
- ☐ Crossed eyes_____
- ☐ **Glaucoma**_____
- ☐ Macular Degeneration_____
- ☐ Retinal Detachment / Disease_____
- ☐ Arthritis_____
- ☐ Cancer_____
- ☐ **Diabetes**_____
- ☐ Heart Disease_____
- ☐ High Blood Pressure_____
- ☐ Kidney Disease_____
- ☐ Lupus_____
- ☐ Thyroid Disease

Social History

Smoking
- ☐ Current daily smoker
- ☐ Current occasional smoker
- ☐ Former smoker
- ☐ Never smoked

Alcohol
- ☐ Daily
- ☐ Occasionally
- ☐ Seldom
- ☐ Never

Do you drive? ☐ Yes ☐ No

Visual difficulty when driving? ☐ Yes ☐ No

Eye Surgeries and Injuries and approximate date ☐ **N/A**

- ☐ Cataract _____
- ☐ Glaucoma _____
- ☐ LASIK _____
- ☐ Retina _____
- ☐ Laser _____
- ☐ Injuries _____

Past Surgeries – and approx. date ☐ **N/A**

_____

_____

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Your *Personal* Medical History

☐ **Check here if no medical problems, medications, or allergies**

Eyes
- ☐ Blurred distance vision
- ☐ Blurred near vision
- ☐ Dryness
- ☐ Crossed eyes
- ☐ Lazy eye
- ☐ Drooping eyelid
- ☐ Cataracts
- ☐ Redness
- ☐ Loss of vision
- ☐ Flashes of light
- ☐ Floaters (spots that move)
- ☐ Itching
- ☐ Burning
- ☐ Excess tearing / watering
- ☐ Light sensitivity
- ☐ Distorted vision / halos
- ☐ Double vision
- ☐ Sandy or gritty feeling
- ☐ Eye pain or soreness
- ☐ Styes
- ☐ Poor Color vision

Cardiovascular
- ☐ **Diabetes**
- ☐ High blood Pressure
- ☐ High cholesterol
- ☐ Irregular heart beat
- ☐ Other vascular disease

Allergic / Immunologic
- ☐ Allergies / Hayfever
- ☐ Hives
- ☐ Itching
- ☐ Sinus pressure

Ear, Nose, Throat
- ☐ Dizziness
- ☐ Runny nose
- ☐ Hearing loss / decrease

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ Cough
- ☐ Wheezing

Gastrointestinal
- ☐ Heartburn
- ☐ Nausea / vomiting
- ☐ Hepatitis / jaundice

Endocrine
- ☐ Thyroid
- ☐ Increased thirst / hunger
- ☐ Increased sweating

Neurological
- ☐ Headaches
- ☐ Migraines
- ☐ Stroke / TIA
- ☐ Numbness
- ☐ Seizures

Integumentary (skin)
- ☐ Eczema / Hives
- ☐ Rashes

Genito-Urinary
- ☐ History of kidney stones
- ☐ Blood in urine
- ☐ History of STD's
- ☐ Pain / difficulty

Musculoskeletel
- ☐ Arthritis
- ☐ Stiffness
- ☐ Joint Pain / swelling
- ☐ Muscle weakness / pain
- ☐ Muscular Dystrophy

Blood / Lymphatic
- ☐ Anemia
- ☐ Bruise easily
- ☐ Bleeding problems

Psychiatric
- ☐ Anxiety / Depression
- ☐ Difficulty sleeping
- ☐ Mood swings

Constitutional
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss / gain

Cancer
- ☐ Type _____

Current Medications – Include: Prescription, over-the-counter, vitamins, supplements. Also list the dosage, how often it is taken and how it is taken (by mouth, injected, etc). If you have a list, we can copy and attach it.

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Glasses and Contact lens history

Do you wear or have you worn ☐ Glasses ☐ Contact lenses

Do they help you see better in the ☐ Distance ☐ Near ☐ Both

If you wear contacts, are they ☐ Soft ☐ Extended wear ☐ Gas permeable

If you wear contacts, are they comfortable? ☐ Yes ☐ No ☐ Dry

Are you interested in ☐ Glasses ☐ Contact lenses ☐ Both

Medication Allergies

_____

_____

Vital Statistics

Height _____ Weight_____

Blood Pressure _____/_____