Dr. Omar Munshi, O.D.
25 South Street
Morristown, NJ 07960
Phone: 973-538-5287
Fax: 973-538-6803

Today's Date: ___________________

PATIENT INFORMATION

Patient Name: ____ Birthdate: _______________ Age: ________

Sex: Male Female Occupation: ____ If Student - Grade ______

Address: _______________________________________ City: ______________________ State: ______ Zip: _________

Phone: Cell ________________________ Home _______________________ Work _______________________

Email: ____ Preferred method of contact: Cell Home Work Email

Who may we thank for referring you to our practice? ____

Name of person responsible for this account (*if patient is minor*): ____

Emergency Contact: ____________________________________ Phone Number: _______________________________

EYE HEALTH HISTORY

Reason for today's exam: ____ Date of last exam: ___________

Do you wear eyeglasses? □Yes □No ***If Yes:*** □Full Time □Occasionally □Reading □Driving/TV

Do you wear contact lenses? □Yes □No ***If No****:* Are you interested in trying contacts? □Yes □No

- How often do you discard your contacts? □Daily □Biweekly □ Monthly □Quarterly □Yearly
- Do you take your contacts out at night? □Yes □No □Sometimes
- What disinfection system/cleaning solution do you use? ____
- Please describe any problems you are having with your contacts: _______________________________________

  ____

Please mark **Yes or No** if you have experienced any of the following:

Blurred Vision-Distance (with or without glasses)	□ Yes	□ No	Glaucoma/High Eye Pressure	□ Yes	□ No
Blurred Vision-Near (with or without glasses)	□ Yes	□ No	Lazy Eye or Crossed Eyes	□ Yes	□ No
Bloodshot Eyes	□ Yes	□ No	Light Flashes	□ Yes	□ No
Cataracts	□ Yes	□ No	Light Sensitivity	□ Yes	□ No
Discharge from Eyes	□ Yes	□ No	Macular Degeneration	□ Yes	□ No
Double Vision	□ Yes	□ No	Retinal Holes/Tears	□ Yes	□ No
Dry/Sandy Eyes	□ Yes	□ No	Seeing Halos	□ Yes	□ No
Eye Injury or Surgery	□ Yes	□ No	Vision Therapy	□ Yes	□ No
Eyestrain	□ Yes	□ No	Watery Eyes	□ Yes	□ No
Frequent Headaches	□ Yes	□ No	Other: _________________________________		

HEALTH HISTORY

Please mark **Yes** or **No** if you have had any of the following.

AIDS/HIV	□ Yes	□ No	Hypertension	□ Yes	□ No
Arthritis	□ Yes	□ No	Kidney Disease	□ Yes	□ No
Asthma	□ Yes	□ No	Liver Disease	□ Yes	□ No
Autoimmune Disorder	□ Yes	□ No	Stroke	□ Yes	□ No
Cancer	□ Yes	□ No	Thyroid Condition	□ Yes	□ No
Diabetes	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Heart Condition	□ Yes	□ No	Alcohol Use	□ Yes	□ No
Hepatitis	□ Yes	□ No	Tobacco Use	□ Yes	□ No

Other: ____

Please list any medications you are currently taking (*Including eye drops or over the counter medication):*

____

____

Please list any allergies to medication: ____

____

FAMILY HISTORY

Please mark **Yes or NO** if anyone in your family has had any of the following**.**

Blind Eye	□Yes □No	Diabetes	□Yes □No
Cataracts	□Yes □No	Glaucoma	□Yes □No
Crossed or Lazy Eye	□Yes □No	Retinal Disease	□Yes □No

Other: ____

LIFESTYLE HISTORY

Knowing how you use your eyes allows us to better address your visual needs

Approximately how many hours do you spend on the computer daily? ____________________________________

Approximately how much time do you spend outdoors for either work or recreation? __________________________

Do you perform fine or up-close work? □Yes □No ***If Yes,*** please specify what type: __________________________

What sports or recreational activities do you enjoy?

□ Baseball/Softball	□ Racquet Sports
□ Basketball	□ Shooting Sports
□ Cycling	□ Skiing/Snow Sports
□ Fishing/Water Sports	□ Soccer
□ Golf	
□ Motorcycle	□ Other: __________________