Dr. Steven R. Koganovsky
Optometric Physician

Adult and Pediatric Eye Care

Specialization in Contact Lenses And Children's Vision

Sports Vision Consultant

WELCOME TO OUR OFFICE

In order to aid in evaluating your Ocular Health please complete the following questionaire . IT IS VERY IMPORTANT THAT YOU FILL THIS OUT IN ITS ENTIRETY. This will become a part of your office record and will be held in strict confidence.

Name: Mr.[] Mrs.[] Miss[] Ms.[] Dr.[] _____Today's Date_____

Address:_____SS#_____ Medicare Suffix:_____

City and State:_____Zip Code_____Insurance Co._____

Telephone: Home_____Work:_____Mobile:_____E-MAIL_____
Birthdate:_____Age:_____ Marital Status: M[] S[] Div[] Sep[] Wid[] Minor[]
Occupation:_____Employer_____
To whom may we thank for referring you to our office_____
Preferred Method of Payment: Cash/Check[ ] Mastercard[ ] Visa[ ]

Family Physician_____Address and Telephone_____

Date of Last Physical Examination_____ Date of Last Eye Examination_____

GENERAL AND OCULAR HEALTH QUESTIONAIRE (CHECK APPROPRIATE BOXES) :

CHECK THE BOX AFTER EACH CONDITION THAT AFFECTS YOU OR ANY BLOOD RELATIVE:

SELF	REL	SELF	REL	SELF	REL
[ ]GLAUCOMA	[ ]	[ ]CROSSED EYE	[ ]	[ ]DIABETES	[ ]
[ ]CATARACT	[ ]	[ ]EYE SURGERY		[ ]ARTHRITIS	[ ]
[ ]EYE INJURY		[ ]HEAD INJURY		[ ]HEART DISEASE	[ ]
[ ]VISION LOSS	[ ]	[ ]EYE INFECTION		[ ]BLOOD PRESSURE	[ ]
[ ]LAZY EYE	[ ]	[ ]RETINAL DETACH		[ ]THYROID	
[ ]ALLERGIES		[ ]EYE MUSCLE IMBALANCE	[ ]	[ ]SINUS PROBLEMS	[ ]
		[ ]MACULAR DEGENERATION	[ ]	[ ]LUNG PROBLEMS	
				[ ]HIV POSITIVE	
				[ ]CANCER/TUMORS	[ ]

ARE YOU INTERESTED IN LASER VISION CORRECTION? YES[ ] NO [ ] MAYBE [ ]

LIST ANY MEDICATIONS YOU CURRENTLY TAKE_____

LIST ANY EYEDROPS YOU CURRENTLY TAKE_____

LIST ANY ALLERGIES TO MEDICATIONS_____

MY VISION IS CURRENTLY DIFFICULT FOR : READING[ ] DRIVING [ ] SPORTS [ ] COMPUTER[ ]

I WEAR MY GLASSES FOR DISTANCE [ ] READING [ ] COMPUTER WORK [ ] ALL ACTIVITES[ ]

REASON FOR TODAY'S EXAMINATION: *PLEASE CHECK ONE OR MORE OF THE FOLLOWING*

ROUTINE/GLASSES [ ] GLARE OR LIGHT SENSITIVITY [ ] LOST/BROKEN GLASSES [ ]
CONTACT LENSES [ ] BLURED VISION [ ] LOSS OF VISION [ ] INJURY [ ] RED EYE(S) [ ]
PAIN SWELLING[ ] ITCHING [ ] HEADACHES[ ] GLAUCOMA [ ] CATARACTS [ ] TEARING [ ]
DOUBLE VISION [ ] DRY EYES [ ]