Cates
Family Eye Care
Perfect Vision, Personal Care

J. Travis Cates, OD
Angela K. Cates, OD
2001 Chester Blvd. • Richmond, IN 47374
# 765-966-0583 • Fax: 765-962-0960
catesfec@gmail.com

# Welcome to Cates Family Eye Care

Patient Name _____

Date: _____

Primary Care Doctor: _____
(Medical Doctor)
Doctor's Address: _____

Reason for you visit today: _____

Date of last eye exam: _____

Are you interested in being fitted (if necessary) for: ◯ Glasses ◯ Contacts ◯ Both

Date of Last Medical Exam: _____

Do you currently wear: ◯ Glasses ◯ Contacts ◯ Both

If you currently wear contacts, do you sleep in them? ◯ Yes ◯ No

*** Please be advised that there is an additional fitting fee for the fitting of contact lenses, which will be charged at each annual exam.***

**Chief Complaint:** Please explain any and all difficulties you are experiencing with you vision: _____

_____

Please explain any difficulties you are experiencing with the comfort of your eyes: _____

_____

**Computer Usage:** Do you use the computer at home or work: ◯ Yes ◯ No Please explain any difficulties: _____

_____

Surgeries: Please list all surgeries you have had: Systemic (body): _____

_____

Eye: _____

Are you interested in Refractive surgery (Lasik)? ◯ Yes ◯ No

**Family History of Eye Problems** (relationship i.e. maternal grandmother)

Blindness: None ☐ Yourself ☐ Family Member ☐ _____

Eye Turn: None ☐ Yourself ☐ Family Member ☐ _____

Glaucoma: None ☐ Yourself ☐ Family Member ☐ _____

Macular Degeneration: None ☐ Yourself ☐ Family Member ☐ _____

Retinal Detachment: None ☐ Yourself ☐ Family Member ☐ _____

Other: _____

Medications: Please List all: ☐ None Systemic: _____

Medications: Eye: _____

Please list any medication allergies: ☐ None _____

Please list any other allergies: ☐ None _____

Social History: Do you use tobacco? ☐ No ☐ Former ☐ Current, Usage: _____

Do you drink alcohol? ☐ No ☐ Yes ☐ Social 1-2 Drinks Daily ☐ Above Average Other: _____

Non-prescribed drug usage: ☐ No ☐ Yes Recreational Other: _____

Review of systems (Please tell us about your medical history) Height: _____ Weight: _____

Allergies: ☐ None ☐ Environmental Allergies ☐ Food Allergies ☐ Animal Allergies

Other:

Cardiovascular: ☐ None ☐ High Blood Pressure ☐ Heart Disease ☐ High Cholesterol ☐ Stroke

Other:

Constitutional: ☐ None ☐ Appetite Problems ☐ Sleep Problems ☐ Fainting ☐ Dizziness ☐ Fever

Other:

Endocrine: ☐ None ☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Crohn's ☐ Thyroid ☐ Gout

Other:

Gastrointestinal: ☐ None ☐ Acid Reflux ☐ Colitis ☐ Cancer ☐ GERD ☐ Hepatitis ☐ IBS

Other:

Genitourinary: ☐ None ☐ Bladder ☐ Infections ☐ Ovarian Tumor ☐ Prostate Cancer ☐ STD

Other:

Head : ☐ None ☐ Encephalitis ☐ Headaches ☐ Hearing Loss ☐ Migraines Meniere's

Other:

Hemotologic/lymphatic: ☐ None ☐ Anemia ☐ Clotting Disorder ☐ Leukemia ☐ Lymphatic Cancer ☐ Sickle Cell Other:

Immunologic: ☐ None ☐ AIDS ☐ Herpes ☐ Lyme Disease ☐ Reye's Syndrome ☐ Sjogren's ☐ Sarcoidosis Other:

Integumentary (skin): ☐ None ☐ Acne Eczema (Atoptic Dermatitis) ☐ Lupus ☐ Psoriasis ☐ Ocular Rosacea Other:

Musculoskelatal: ☐ None ☐ Arthritis ☐ Down's Syndrome ☐ Muscular Dystrophy ☐ Osteoporosis

Other:

Neurological: ☐ None ☐ Bell's or Cerebral Palsy ☐ Epilepsy ☐ Parkinson's ☐ Seizures ☐ Vertigo Other:

Psychiatric: ☐ None ☐ Anxiety ☐ Autism ☐ Bipolar ☐ Dementia ☐ Depression ☐ Schizophrenia Other:

Respiratory: ☐ None ☐ Asthma ☐ Bronchitis ☐ CO/PD ☐ Emphysema ☐ Lung Disease ☐ Tuberculosis Other:

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