

**Dr. Michael J. Bermel, P.C.**  
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**OPTOMETRISTS**

**MEDICAL HISTORY**

\_\_\_\_\_  
Patient Name (please print)

\_\_\_\_\_  
Date of Birth

Do you have problems with any of these systems? **Circle Y or N as apply:**

Gastrointestinal Y / N    Nervous Y / N    Endocrine Y / N    Ear/Nose/Throat Y / N  
Genitourinary Y / N    Mental Y / N    Cardiovascular Y / N    Musculoskeletal Y / N  
Blood/Lymph Y / N    Respiratory Y / N    Skin Y / N    Allergy/Immunologic Y / N

If Y to any, please explain: \_\_\_\_\_  
\_\_\_\_\_

Please answer Current Medical Questions: **Circle Y or N as apply:**

Diabetes Y / N    Type: \_\_\_\_\_    Date of Diagnosis: \_\_\_\_\_  
High Blood Pressure Y / N    Controlled by: \_\_\_\_\_ Medication    \_\_\_\_\_ Diet  
Allergies Y / N    Please list: \_\_\_\_\_  
Medication Allergies: \_\_\_\_\_  
Current medications: \_\_\_\_\_  
Other health problems: \_\_\_\_\_  
Have you had any operations? Y / N    Kind: \_\_\_\_\_  
Do you use cigarettes/tobacco? Y / N    Alcohol? Y / N    Other substances? Y / N \_\_\_\_\_  
Name of Family Doctor: \_\_\_\_\_    Date of last visit: \_\_\_\_\_  
Date of last Tetanus shot: \_\_\_\_\_

**FAMILY HISTORY** **Circle Y or N as apply:**

High Blood Pressure Y / N    Relation \_\_\_\_\_    Diabetes Y / N    Relation \_\_\_\_\_  
Heart Disease Y / N    Relation \_\_\_\_\_    Glaucoma Y / N    Relation \_\_\_\_\_  
Macular Degeneration Y / N    Relation \_\_\_\_\_    Cataracts Y / N    Relation \_\_\_\_\_  
Retinal Detachment Y / N    Relation \_\_\_\_\_  
Other Eye Condition(s) Y / N    Explain \_\_\_\_\_

**PERSONAL EYE INFORMATION**

Please check all that apply:

\_\_\_\_ Headaches                      \_\_\_\_ Glasses                      \_\_\_\_ Contacts                      \_\_\_\_ Blur—Near  
\_\_\_\_ Blur—Distance                      \_\_\_\_ Flashes of Light                      \_\_\_\_ Floating Spots  
\_\_\_\_ Loss of Vision                      \_\_\_\_ Double Vision                      \_\_\_\_ Other

Eye Operations? Y / N    Type: \_\_\_\_\_  
Eye Injuries? Y / N    Kind: \_\_\_\_\_  
Additional Information: \_\_\_\_\_  
Date of Last Eye Exam: \_\_\_\_\_    Dilated Y / N    Previous Doctor: \_\_\_\_\_

Leesburg ▪ 55A Catocin Circle NE ▪ 20176 ▪ (703) 777-3455  
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Ashburn ▪ 43330 Junction Plaza # 120 ▪ 20147 ▪ (703) 726-9600  
Gainesville ▪ 7531 Somerset Crossing Drive ▪ 20155 ▪ (571) 261-5100

MEDICAL HISTORY, CONTINUED

Please list your hobbies: \_\_\_\_\_  
\_\_\_\_\_

How many **total hours** of near activity (out to 3 feet) do you perform **per day**? (For example: computer use, reading, computer games, typing, filing, piano playing) Include all activity, even if intermittent, and provide a total number of hours:  
\_\_\_\_\_

**DRY EYE CHECKLIST**

- Red Eyes       Burning       Itching       Foreign Body Sensation
- Sandy/gritty feeling       Light Sensitivity       Watery Eyes       Dry Eyes
- Occasional tearing       Constant Tearing       Pain or Soreness In/Around Eyes
- Tired Eyes       Contact Len Discomfort       Seasonal Allergies
- Dry Throat or Mouth       Arthritis/Joint Pain       Decreased Contact Lens Tolerance

If you experience the symptoms above, you may be suffering from Dry Eye Syndrome. Left untreated, your symptoms will most likely intensify, making your daily life unpleasant or worse, deteriorate your visual acuity.

Are you interested in improving your vision without surgery, eyeglasses or conventional contact lenses with gentle molding?  Yes       No      Would you like more information? \_\_\_\_\_

What Sun protection are you Currently using? \_\_\_\_\_ For your eyes? \_\_\_\_\_

- Thinner and lighter lenses for high prescriptions       Laser Surgery
- Invisible bifocals       Gentle Molding
- Ultra-Violet protection       Sports Vision
- Anti-glare glasses       Developmental Vision/ Visual Therapy
- Sunglasses
- Colored contacts
- Disposable contacts
- Rigid Gas Permeable Contacts

Please help us serve you. How did you hear about our office?

- Insurance company
- Yellow Pages       Walk By
- The Community Phone Book       Referral, By Whom? \_\_\_\_\_
- Internet
- Other \_\_\_\_\_

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date

Reviewed:

\_\_\_\_\_  
Date Appt. Scheduled

\_\_\_\_\_  
Tech Initials

\_\_\_\_\_  
Doctor Initials

*Thank you for choosing us to serve your vision needs!*