

DOWN TOWN EYES

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WELCOME TO OUR OFFICE

Please Print

Name _____

Street _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Employer _____

Occupation _____

Medical History

Allergies	No	Yes	Arthritis	No	Yes
Asthma	No	Yes	Cancer	No	Yes
Skin Disorder	No	Yes	Diabetes	No	Yes
Eye Diseases	No	Yes	Heart Disease	No	Yes
Eye Injury	No	Yes	High Blood		
Eye Surgery	No	Yes	Pressure	No	Yes
Lazy Eye	No	Yes	Kidney	No	Yes
Cataracts	No	Yes	Glaucoma	No	Yes

Other _____ No Yes

Current Medications (Rx or Over the Counter)

	No	Yes	Name of Medication
Antihistamines			_____
Diuretics (Water Pills)			_____
Blood Pressure Pills			_____
Oral Contraceptives			_____
Eye Drops			_____
Other			_____

Are you currently under the care of a physician? No Yes
Name of physician _____

Family Medical History

	No	Yes	Relationship
Blindness			_____
Cataracts			_____
Glaucoma			_____
Diabetes			_____
Macular degeneration			_____
Other			_____

Today's Date _____ Date of Last Exam _____

Date of Birth _____ Age _____ Sex: M F

What is the major purpose of this visit? _____

Any problems with your present contact lenses or glasses? _____

If Child - Parent's Work Phone: _____

Health/Vision Insurance: _____

Do you participate in a flexible spending account? Yes No

How will you settle your account today?

Check Cash Credit Card

Do you...

...Work at a computer for long periods? Yes No
 ...Have more than one pair of glasses? Yes No
 ...Want information on thinner, lighter lenses? Yes No
 ...Wear Bifocals? Yes No
 ...If yes, are you bothered by head tilting,
 restricted areas of vision correction, etc.? Yes No
 ...Always like to wear your glasses? Yes No
 ...Have prescription sunglasses? Yes No
 ...Have problems with glare or reflection,
 particularly when driving at night? Yes No
 Have you ever worn/are you currently
 wearing contacts? Yes No
 If yes, where were you last fit? _____
 Are you interested in contact lenses? Yes No
 Sports and Hobbies _____

Would you like information about
 refractive surgery? Yes No

Do you experience...

Burning Spots Uncomfortable glasses
 Itchiness Soreness Sudden loss of vision
 Nausea Flashes of light Sensitivity to light
 Watery Eyes Headaches Fainting or dizziness
 Tearing Redness Blurry distance vision
 Dryness Eye strain Blurry near vision
 Trouble working up close Reading problems
 Objects floating in vision Glare or reflection
 Trouble seeing at night Gritty feeling in eyes
 Uncomfortable contact lenses Double vision
 Other _____

Whom may we thank for referring you to our office?

