WELCOME TO OUR OFFICE

Today's Date: ______________________________

Name: ____________________________________

Date of Birth:___/____/______ Age:_____ Sex: M/F_____

Street: ____________________________________

City:______________________ State____ Zip_________

Primary Phone: ______________________________

Alternate Phone: _____________________________

Email: ____________________________________

Social Security Number: _______________________

Employer/School: _____________________________

Occupation/Grade: ____________________________

Martial Status? (circle) M S W D

MEDICAL HISTORY

(Please circle Y or N)

Y / N Currently Pregnant Due: ________________
Y / N Allergies
Y / N Asthma
Y / N Arthritis
Y / N Diabetes Diagnosis Date:________________
Y / N High Cholesterol
Y / N Hypertension (high blood pressure)
Y / N Heart Disease
Y / N Thyroid Disorder
Y / N Auto Immune Disorder Type:________________
Y / N Cancer Type: __________________________
Y / N Kidney Problems Type: __________________
Y / N Nerve Problems Type: ___________________
Y / N Skin Disorder Type: _____________________
Y / N Eye Injury Type: _______________________
Y / N Cataracts
Y / N Glaucoma
Y / N Macular Degeneration
Y / N Eye Surgeries
Please list:______________________________

Other: ____________________________________

____

Primary Care Physician:

____

Date of Last Full Eye Exam: ____________________

Current Medications

Please list all prescription, non-prescription, Vitamins, and supplements including ***dosages.***

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Family Medical History Relationship

Y / N Heart Disease ___________________________
Y / N Diabetes ______________________________
Y / N Cancer________________________________
Y / N Cataracts______________________________
Y / N Glaucoma______________________________
Y / N Macular Degeneration____________________
Y / N Other: ________________________________

Other Info

Any allergies to medications? Y / N
If so, please list ___________________________
Tobacco Use? Y / N
What type _________________________________
Alcohol Use? Y / N
How often _________________________________

Do You?

Y / N Have a spare pair of glasses?
Y / N Have prescription sunglasses?
Y / N Have problems with glare?
Y / N Work at a computer for long periods of time?
Y / N Current contact lens patient?
Y / N If not, are you interested in contact lenses?

Do You Experience?

Y / N Blurry distance vision
Y / N Burry near vision
Y / N Dryness
Y / N Burning
Y / N Excess tearing
Y / N Objects floating in vision
Y / N Flashes of light in vision