Date _____

Last Name _____ First Name _____ M.I. _____ M / F

SSN _____ Age _____ Date of Birth _____ Primary Phone _____

Home Address _____ City _____ State _____ Zip _____

Occupation _____ Employer _____ Cell Phone _____

Work Adress _____ City _____ Work Phone _____

Email _____

Parent or Spouse (circle) _____

Vision Insurance Co. _____ Medical- Insurance: Primary _____ Secondary _____

MEDICAL INFORMATION

How is your general health? _____ Date last health exam: _____

Do you have problems with any of these systems? (Please check all that apply)

☐ Gastrointestinal ☐ Nervous ☐ Mental ☐ Respiratory

☐ Eyes/Ears/Nose/Throat ☐ Genitourinary ☐ Endocrine ☐ Integumentary (skin)

☐ Cardiovascular ☐ Musculoskeletal ☐ Blood/ Lymph ☐ Allergic/Immunologic

Please explain: _____

Please answer all that apply:

☐ Diabetes Type _____ Date of Diagnosis: _____

☐ Allergies Allergic to what? _____ What happens? _____

☐ Medication Allergy What happens? _____ Headaches (Yes / No) _____

Other health problems _____

Current Medication(s) _____

Have you had any operations? Y / N Kind? _____ When? _____

Do you use cigarettes/tabacco? _____ Alcohol? _____ Other substances? _____

Name of family doctor _____ Date of last tetnus shot? _____

FAMILY HISTORY

Blood relatives who have:

High Blood Pressure_____ Macular degeneration_____

Diabetes_____ Retinal detachment _____

Glaucoma_____ Cataracts _____

Other eye condition(s):_____

PERSONAL EYE INFORMATION

Please answer all that apply:

Date of last eye exam_____ Dilated? Yes No

Have you had any eye operations?_____ Type _____ Date _____

Have you had an eye injury? _____ Kind _____Date _____

Do you have: Glaucoma _____ Cataracts _____ Dry eyes _____ Blurred vision ____

Itching _____ Burning _____Tearing _____ Flashes/floaters _____

Do you wear glasses for: Distance _____ Near _____ Both _____ Contact lenses Y/N Type _____

Do you work on computer or VDT? _____ How many hours per day? _____

* Whom may we thank for referring you to this office? _____

Signature:_____ Date _____ Doctor's initials _____

The above medical information has not changed since my last visit.

*Signature:*_____ *Date:*_____ *Signature:* _____*Date:* _____

Signature: _____ *Date:* _____ *Signature:* _____*Date:* _____

Signature: _____ *Date:* _____ *Signature:* _____*Date:* _____

Signature: _____ *Date:* _____ *Signature:*_____*Date:* _____