PATIENT INFORMATION

Welcome to Our Office! Today's Date:_____

Patient Name:_____ Birth Date:_____ Age:_____

Address:_____ Phone: _____

City/Zip _____ Work:_____

E-mail (optional):_____ Cell:_____

Guardian (if applicable):_____ SSN:_____/_____/_____

Address:_____ Occupation:_____

City/Zip _____ Employer:_____

How did you hear about us?_____

Medical History

Reason for today's exam:_____ Last Eye Exam:_____

Any allergies to medications? ☐No ☐Yes Please list_____

List any current medications (including oral contraceptives, aspirin, over-the-counter medications and home or herbal remedies)

_____

_____

List any major injuries, surgeries and/or hospitalizations you have had:_____

_____

Circle any of the conditions you have/had: Crossed-eyes Lazy-eye Droopy Eyelids Glaucoma Cataracts Retinal Disease Eye Infections Eye Injury Eye Surgery:_____

Are you pregnant or nursing? ☐No ☐Yes How long?_____

Do you wear glasses? ☐No ☐Yes How old is your current pair?_____

Do you wear contact lenses? ☐No ☐Yes How old is your current pair?_____

Type of contacts: ☐Rigid ☐Soft ☐Disposables ☐Extended Wear Are they comfortable? ___

How many hours do you spend in front of a computer per day?_____

Family History

Please note any family history (including parents, grandparents, siblings, children, living or deceased) for the following:

Disease/Condition	Yes	No	?	Relationship To You
Blindness	☐	☐	☐	_____
Cataracts	☐	☐	☐	_____
Crossed Eyes	☐	☐	☐	_____
Glaucoma	☐	☐	☐	_____
Macular Degeneration	☐	☐	☐	_____
Retinal Detachment/Disease	☐	☐	☐	_____
Arthritis	☐	☐	☐	_____
Cancer _____	☐	☐	☐	_____
Diabetes Type I or II	☐	☐	☐	_____
Heart Disease	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Lung Disease	☐	☐	☐	_____
Lupus/Auto-immune Disease	☐	☐	☐	_____
Thyroid Disease	☐	☐	☐	_____
Other _____	☐	☐	☐	_____