Patient's Name________________________________ Date__________

Date of Birth____/___/____ Social Security Number________________

Spouse's Name_______________Parent's Name (if under age)____________________

Mailing Address________________________________City___________Zip__________

Home Phone_________________Cell Phone_______________

Occupation_________________Employer___________________If Student, Grade____

Who will Pay for this Account?______________________

Preferred Payment Method: _____Cash _____Check ____Credit Card

Name of Medical Doctor____________________Last Medical Exam_________

Last Eye Exam______________________By Doctor_____________________

REVIEW OF SYSTEMS

Please circle any conditions you currently have, or have had in the past.

Constitutional
- Fever, Weight Loss/Gain

Ears, Nose, Mouth, Throat
- Allergies/Hay Fever
- Sinus Congestion
- Runny Nose
- Chronic Cough
- Dry Throat/Mouth

Neurological
- Headaches
- Migraines
- Seizures

Psychiatric Problems
- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder

Cardiovascular/Vascular
- Diabetes
- High Blood Pressure
- Heart Pain
- Vascular Disease
- Joint Pain

Respiratory
- Do You Smoke
- Asthma
- Chronic Bronchitis
- Emphysema

Gastrointestinal
- Diarrhea
- Constipation

Genitourinary
- Genitals/Kidney/Bladder

Muscles/Bones/Joints
- Rheumatoid Arthritis
- Muscle Pain

Integumentary
- Skin Problems

Endocrine
- Diabetes
- Thyroid /Other Glands

Hematologic /Lymphatic
- Bleeding Problems
- Anemia

Allergic / Immunologic
- Drug Allergies
- Environmental Allergies

Eyes
- Loss of Vision
- Blurred Vision
- Distorted Vision/Halos
- Loss of Side Vision
- Double Vision
- Dryness
- Mucous Discharge
- Redness
- Sandy or Gritty Feeling
- Itching
- Burning
- Foreign Body Sensation
- Excess Tearing/Watering
- Glare/Light Sensitivity
- Eye Pain or Soreness
- Chronic Eye /Lid Infections
- Sties or Chalazion
- Flashes/Floaters in Vision
- Tired Eyes

PLEASE TURN OVER AND COMPLETE BACK OF THIS FORM

MEDICAL HISTORY

List any Medications with dosages that you take (including oral contraceptives, aspirin, over the counter medications and home remedies):
* (To save you time, if you have a list of your meds written out, we can make a copy of it and give it back to you.)

____________________Dosage______ ____________________Dosage______ ____________________Dosage______
____________________Dosage______ ____________________Dosage______ ____________________Dosage______
____________________Dosage______ ____________________Dosage______ ____________________Dosage______
____________________Dosage______ ____________________Dosage______ ____________________Dosage______

***Do You Have Any Allergies to Medications**? ☐ NO ☐ YES If Yes, List Medications:______________________________

Please Circle Any Of The Following That You Have Had:

Crossed Eyes Lazy Eye Drooping Eyelid Prominent Eyes Eye Infections Glaucoma Retinal Disease Cataracts

Eye Injury, (please explain injury) ____

List all major surgeries and/or hospitalizations you have had______________________________
____

Are you pregnant and/or nursing? ___ No ___Yes

Do you wear Glasses? ___ No ___ Yes If yes, How old is your present pair of Lenses?_____________

Do you wear Contact Lenses ___ No ___Yes If yes, How old is your present pair of Lenses?____________

Circle the type of your contact Lenses: Soft Rigid Extended Wear Dailies Other Are they comfortable? ___Yes ___ No

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SOCIAL HISTORY

This Information is kept strictly confidential. However you may discuss this portion directly with your Doctor if you prefer.

___ Yes, I would prefer to discuss my Social History information directly with my Doctor.

Do you drive? __ No __ Yes If yes, do you have visual difficulty when driving? ___ No ___Yes (If yes, please explain):____

Do you drink alcohol? ___ Yes ___No If yes, type/amount/how long:________________________
Do you use tobacco products? ___ Yes ___No If yes, type/amount/how long:________________________
Do you use illegal drugs? ___ Yes ___No If yes, type/amount/how long:________________________

Have you ever been exposed to or infected with: ☐ Gonorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

Medical History Of Your Family

Please Circle Family Members (living or deceased) for which these conditions apply:

CANCER	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
DIABETES	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
HEART DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
HIGH BLOOD PRESSURE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
THYROID DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
KIDNEY DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
LUPUS	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
ARTHRITIS	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Other Conditions Not Listed:____

CATARACT	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
MACULAR DEGENERATION	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
GLAUCOMA	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
BLINDNESS	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
CROSSED EYES	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
RETINAL DETACHMENT/DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Doctor's Signature__________________

Date_____________