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 ______

Medical Insurance_______________________________________ Policy #_________________________

Secondary Medical_______________________________________Policy #_________________________

Vision Insurance ____ Policy #_______________________

**The patient is responsible for any amount not covered by the insurance company (copays & deductibles). This amount is due on the date of service unless prior financial arrangements have been made.

Name of Medical Doctor______________________ Last Medical Exam______________ Pharmacy ____________

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
- Cancer (kind)____________

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

- High Blood Pressure
- Stroke
- Heart Pain
- Vascular Disease
- High Cholesterol

Respiratory

- Smoker
- Asthma
- Chronic Bronchitis
- Emphysema

Gastrointestinal

- Diarrhea
- Constipation

Genitourinary

- Genitals/Kidney/Bladder

Muscles/Bones/Joints

- Rheumatoid Arthritis
- Muscle Pain
- Joint Pain

Integumentary

- Skin Problems

Endocrine

- Diabetes
- Thyroid /Other Glands

Hematologic /Lymphatic

- Bleeding Problems
- Anemia
- High Cholesterol

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
- Crossed Eye
- Lazy Eye
- Drooping Eyelid
- Prominent eye
- Eye Infections
- Glaucoma
- Retinal Disease
- Cataracts
- Cataract Surgery date___________
- Macular Degeneration
- Eye Injury (Date)_______________
- Eye Injury (Info) _______________

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.)

NONE: ☐

______ 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:______________________________

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

Are you pregnant and/or nursing? ___ Yes ___No
Do you wear Glasses? ___ Yes ___ No If yes, How old is your present pair of Lenses?_____________
Do you wear Contact Lenses ___ Yes ___No 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

---

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? __ Yes __ No If yes, do you have visual difficulty when driving? ___ Yes ___No (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
AUTOIMMUNE DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
DIABETES	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
CARDIOVASCULAR DISEASE	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Other Conditions Not Listed:______________________________

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

Doctor's Signature____________________
Date______________