

Patient's Name _____ Date _____

Updated 2024

Date of Birth ____/____/____ Social Security Number _____



E-mail Address _____

Mailing Address _____ City _____ State _____
Zip Code _____

Home Phone _____ Cell Phone _____

Spouse's Name _____ Parent's Name (if under age) _____

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
Gonorrhea
Hepatitis
Syphilis
HIV

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
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.)

MARK HERE IF YOU DO NOT TAKE ANY MEDICATION

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 use tobacco products? Yes No

If yes, type/amount/how long:

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
Other Conditions Not Listed:							
GLAUCOMA	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
MACULAR DEGENERATION	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
RETINA DETACHMENT	Father	Mother	Brother	Sister	Son	Daughter	Grandparent
BLINDNESS	Father	Mother	Brother	Sister	Son	Daughter	Grandparent

Doctor's Signature Date