

Today's Date: _____

GENERAL INFORMATION

Name (First, MI, Last & Preferred): _____ Date of Birth: _____
Address: _____ Gender: Male Female
City, State, Zip: _____
Social Security # _____

Please list your Phone #, then check which # you prefer to be contacted:

Home: _____ Work: _____ Cell: _____
E-mail: _____

Race (please circle): Caucasian African American Hispanic/Latino Asian Indian
Multiracial American Indian Hawaiian African Arab Unknown

Ethnicity (please circle): Hispanic/Latino Not Hispanic/Latino

Language: _____

Employer (or School): _____ Occupation (or Grade): _____

Emergency Contact and Phone #: _____

If married, name of spouse _____ If child, name of parents _____

EYE HEALTH HISTORY:

Last eye exam: _____ Doctor/Location: _____

Do you currently wear contact lenses? Yes No. If yes, what kind? _____

Do you wear glasses? Yes No. If yes, how old are they? _____

Have you been experiencing any of the following?

- Blurred Vision
- Flashes
- Floaters
- Light Sensitivity
- Burning/Sandy Feeling
- Dry Eyes
- Redness
- Tired/Strained Eyes
- Itching
- Watery Eyes

Are you interested in?

- Contact Lenses
- Lasik
- Computer glasses
- Sports glasses
- Sunglasses

Any specific visual/eyewear needs for your work or hobbies? _____

Do you currently work at a computer for long periods? How long per day? _____

Is there a family history of any of the following? (Explain relationship)

- Glaucoma _____
- Macular Degeneration _____
- Cataracts _____
- Retinal Detachment/Tear _____
- Lazy Eye _____
- Other Eye Disease _____
- Type II Diabetes _____
- Type I Diabetes _____
- Hypertension _____
- Cancer _____
- Hyperthyroid _____
- Hypothyroid _____

Current Medications (Include over-the-counter, eye drops/meds, vitamins, oral contraceptives)

Have you experienced or been diagnosed or treated for: (If yes, check box and explain below)

EYES

- Cataracts
- Glaucoma
- Macular Degeneration
- Dry Eye Syndrome
- Retinal Tear/Detachment
- Lazy Eye
- Eye Injury
- Eye Surgery/LASIK

CONSTITUTIONAL

- Developmental Disability
- Cancer

EAR/NOSE/THROAT

- Hearing Loss
- Sinusitis

NEUROLOGICAL

- Multiple Sclerosis

OTHER: _____

Stroke

- Migraines
- Concussion

PSYCHIATRIC

- Depression
- Anxiety Disorder
- Bipolar Disorder

CARDIOVASCULAR

- High Blood Pressure
- Heart Disease
- Vascular Disease

RESPIRATORY

- Asthma
- COPD
- Sleep Apnea

GASTROINTESTINAL

- Crohn's, Colitis

GENITOURINARY

- Kidney Disease
- Sexually Transmitted Disease

MUSCULOSKELATAL

- Osteoarthritis

SKIN

- Rosacea
- Eczema/Psoriasis

ENDOCRINE

- Diabetes
- Thyroid dysfunction

HEMATOLOGIC/LYMPHATIC

- Anemia
- High Cholesterol

ALLERGY/IMMUNOLOGIC

- Rheumatoid Arthritis
- Lupus

Please Explain: _____

Primary Physician: _____ Clinic/Location: _____ Last Exam: _____

Height: _____ Weight: _____

If female: Are you currently pregnant? Yes or No Are you Nursing? Yes or No

Allergies

Are you allergic to any medications? Yes No. If yes: _____

Do you have any environmental allergies/hay fever? Yes No

Social History:

Do you use any tobacco products? Yes No How often _____ Have you ever smoked? Yes No

Do you drink alcohol? Yes No How often _____

How did you hear about our office? (Please check box and list name)

Friend/Relative: _____ Another Healthcare Provider: _____

Internet: _____ Event/Other: _____