NAME:_____ DOB:_____

Today's Date:_____ Gender M F Marital Status M S

Address_____City_____Zip_____

Parent or Guardian(under 18)_____

Phone #'s home_____ cell_____

work_____

email_____

Occupation_____ Employed by_____

Vision Insurance_____ Policy #_____

Medical Insurance_____ Policy #_____

Subscriber_____ Member's Birthdate_____

Where did you have your last eye exam_____ when_____

Have you been dilated before? Y N

Reason for today's exam_____

_____

Do you wear glasses? Y N Do you/have you worn contacts? Y N
If yes, at what age did you begin?_____ If yes, at what age did you begin?
If no, have you ever worn glasses? Y N Do you have back up glasses? Y N

Are you interested in contact lenses today? Y N LASIK? Y N

Please lists any sports, hobbies or recreational activities that you enjoy_____

_____

List any family members who are patients_____

Who may we thank for referring you to our office_____

SOCIAL/PREVENTATIVE HISTORY

Do you smoke or chew tobacco? Y N Former

Do you drink alcohol? Y N Former Social

Do you have any of the following? circle condition or add if not listed

Cardiovascular(high blood pressure, heart disease, other) Y N

Constitutional(blackouts, dizzy, fatigue) Y N

Endocrine(Cholesterol, Diabetes, Pituitary, Thyroid) Y N

Gastrointestinal(Ulcerative Colitis, Crohn's) Y N

Genitourinary(Prostate Disorder, Menopause) Y N

Hematologic/Lymphatic(Hodgkin's, Leukemia, Sickle Cell, Coagulation Disorder) Y N

Immunologic(Lyme, Sarcoid, Herpes) Y N

Integumentary(Acne, Rosacea) Y N

Musculoskeletal(Arthritis) Y N

Neurologic(Headache, Migraine, Bell's Palsy, Multiple Sclerosis,Parkinson's) Y N

Psychiatric(ADD/ADHD, Autism, Alzheimer, Depression) Y N

Respiratory(Asthma, COPD, Cystic Fibrosis) Y N

Cancer Y N _____

OCULAR HISTORY

Do you have any eye conditions or problems Y N What kind_____

Including: Glaucoma, cataracts, Macular Degeneration, Dry Eyes, Allergies, Conjunctivitis/Pink Eye

Have you had any eye surgeries Y N Type/date_____

Have you ever had to wear an eye patch or do eye exercises Y N

Have you had an eye injury Y N Kind/date_____

List any MEDICATIONS you are currently taking(prescription or over the counter/ systemic or ocular)_____

_____

Do you have any allergies Y N please list_____

Family Medical/Ocular History:

Does anyone have the above medical/ocular conditions Y N

if yes, please list_____

HIPAA Privacy Acknowledgment of Receipt of Privacy Notice

Patient Signature or Guardian_____Date_____