Today's Date: _____/_____/_____ **DOB**:_____

Name:_____ **Sex**: M F

Address:_____

City/State/Zip:_____

Best Contact Phone #:(_____)_____-_____**Email**:_____

Social Security: (*Needed for Insurances Purposes Only*) _____-_____-_____

How did you learn of our office? □ RELATIVE □ FRIEND □ INSURANCE □ NEWSPAPER
□ WEBSITE □ FACEBOOK □ EMAIL □ Other:_____

Primary Care Physician:_____ **Phone #:**_____

PHARMACY INFORMATION Name:_____

Location:_____ Phone #:_____

INSURANCES; ***Our services may be covered by both medical and vision insurances. Please provide ALL insurance information. Thank you.***

Do you have Vision Insurance? YES NO **If YES**, Name of Insurance:_____

Insurance ID #:_____Primary Insurance Holder: SELF SPOUSE OTHER

If SPOUSE/OTHER: (Please Fill Out Entirely) Full Name of Spouse:_____

DOB of Spouse:_____SS# of Spouse_____/_____/_____ ZIP:_____

Do you have Medical Insurance? YES NO **If YES**, Name of Insurance:_____

Insurance ID #:_____Primary Insurance Holder: SELF SPOUSE OTHER

If SPOUSE/OTHER: (Please Fill Out Entirely) Full Name of Spouse:_____

DOB of Spouse:_____SS# of Spouse_____/_____/_____ ZIP:_____

FAMILY **EYE HISTORY:**
Do any of your ***blood relatives*** have a history of the following conditions:

- □ Crossed Eyes
- □ Amblyopia/Lazy Eye
- □ Blindness
- □ Cataract
- □ Double Vision
- □ Eye trauma/injury
- □ Macular Degeneration
- □ Glaucoma
- □ Retinal Detachment
- □ Refractive/Lasik Procedure
- □ Other:_____

YOUR **EYE HISTORY:**
Do you currently have or previ conditions:

- □ Flashes of light
- □ Floaters
- □ Double Vision
- □ Crossed Eyes
- □ Amblyopia/Lazy Eye
- □ Blindness
- □ Cataract
- □ Double Vision
- □ Eye trauma/injury
- □ Macular Degeneration
- □ Glaucoma
- □ Retinal Detachment
- □ Lasik/PRK Surgery
- □ Blind spot in vision
- □ Distorted vision/halos
- □ Mucous discharge
- □ Burning Eyes
- □ Gritty/sandy sensation
- □ Dry eyes
- □ Red eyes
- □ Watering eyes
- □ Itching
- □ Light sensitivity
- □ Other:_____

VISION CORRECTION Do wear eye glasses? YES NO
Do you wear Contact Lenses? YES NO **If YES**, What Brand of Contacts?_____

EYE SURGERIES: Have you had any previous eye surgeries? YES NO **If YES,** please list surgeries below:

1._____ Eye: Right /Left Date of Surgery:_____/_____/_____

2._____ Eye: Right /Left Date of Surgery:_____/_____/_____

***YOUR* MEDICAL HISTORY:**
Do you have any of the following conditions:

ALLERGIC/ IMMUNOLOGIC
- ☐ Autoimmune Disorders
- ☐ Airborne allergies
- ☐ Frequent infections

BONES/JOINTS/MUSCLES
- ☐ Muscle aches
- ☐ Arthritis
- ☐ Gout

CANCER
- ☐ Breast
- ☐ Prostate
- ☐ Skin
- ☐ Other_____

CARDIO/VASCULAR
- ☐ Chest pain
- ☐ Irregular heart beat

(CONT'D)
- ☐ Swelling of legs
- ☐ Carotid Artery Disease
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Surgery
- ☐ High/Low Blood Pressure
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Stroke
- ☐ T.I.A.

CONSTITUTIONAL
EARS/NOSE/THROAT
- ☐ Hearing loss
- ☐ Hearing Aides
- ☐ Sinus infection
- ☐ Sore throat

ENDOCRINE
- ☐ Diabetes I
- ☐ Diabetes II
- ☐ Diabetic Non-insulin
- ☐ Diabetic Insulin
- ☐ Pre-Diabetic
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Thyroid Hypo/Hyper

GASTROINTESTONAL
- ☐ Gastric Reflex/Heartburn
- ☐ Crohn's Disease
- ☐ Blood in urine

LYMPHATIC/ HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Swollen glands

NEUROLOGICAL
- ☐ Alzheimer's
- ☐ Dementia
- ☐ Parkinson's
- ☐ Headaches

PSYCHIATRIC
- ☐ Depression
- ☐ Anxiety

PULMONARY/ RESPIRATORY
- ☐ Asthma
- ☐ Bronchitis
- ☐ COPD
- ☐ Emphysema
- ☐ Sleep Apnea
- ☐ Breathing Difficulty
- ☐ Chronic cough
- ☐ Tuberculosis

OTHER
- ☐ Recent fevers
- ☐ Weight gain/loss
- ☐ Hepatitis _____
- ☐ Kidney Disease
- ☐ Sexually Transmitted Diseases_____
- ☐ HIV/AIDS
- ☐ Phlebitis
- ☐ Seizures/Tremors

SOCIAL HISTORY:
Do you use tobacco? YES NO **If YES**, How many per day?_____ For how many year?_____
Do you drink alcohol? YES NO **If YES**, How much per day?_____ How often?_____

FEMALES Are you currently pregnant or nursing? YES NO **If NO**, Do you think you MAY be pregnant? YES NO

ALLERGIES Do you have any allergies to medications? YES NO **If YES**, Please list all medication allergies:

_____

MEDICATIONS Please list all medications you are currently taking, (including over the counter and eye drops):

Name of Medication	Dosage	Directions	Start Date	Stop Date

Patient Signature:_____ _Date:_____
Guardians Signature:_____Date:_____