Today's Date:_____

Name:_____ **DOB**:_____ **Age**:_____ **Sex**: M F

Address:_____

City/State/Zip:_____

Best Contact Phone #:_____ **Secondary Contact Phone #**:_____

Marital Status:_____ **E-mail Address**:_____

Social Security:_____/_____/_____ (Needed for Insurances)

Primary Care Physician:_____ ___ **Eye Specialist**:_____

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

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

Do you have **Vision Insurance**? YES NO **If YES**, Name of Insurance Company:_____
Primary Insurance Holder: SELF SPOUSE OTHER
If SPOUSE/OTHER: (Please Fill Out Entirely) Full Name:_____DOB:_____
SS#_____/_____/_____ ZIP:_____

Do you have **Medical Insurance**? YES NO **If YES**, Name of Insurance Company:_____
Primary Insurance Holder: SELF SPOUSE OTHER
If SPOUSE/OTHER: (Please Fill Out Entirely) Full Name:_____DOB:_____
SS#_____/_____/_____ ZIP:_____

PHARMACY INFORMATION

Name:_____ Location:_____
Phone #:_____ Fax #:_____

VISION CORRECTION

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

ALLERGIES

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

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?_____

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 previously had, any of the following 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
- ☐ Blind spot in vision
- ☐ Distorted vision/halos
- ☐ Mucous discharge
- ☐ Burning Eyes
- ☐ Gritty/sandy sensation
- ☐ Dry eyes
- ☐ Red eyes
- ☐ Watering eyes
- ☐ Itching
- ☐ Light sensitivity
- ☐ Other:_____

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

1._____Right /Left Date:__/__/__ 2._____Right /Left Date:__/__/__

3._____Right /Left Date:__/__/__ 4._____Right /Left Date:__/__/__

***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

FEMALES ONLY Are you currently pregnant or nursing? YES NO

If NO, Do you think you MAY be pregnant? YES NO

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:_____