WELCOME TO OUR OFFICE

Today's Date: ___/___/___

Name ______________________________ Date of Birth ______________

Address ______________________________ Occupation ______________

______________________________ Hobbies ______________

Phone (_____)____________ Cell (_____)____________ Work (_____)____________

E-mail Address ______________________________

Name of Medical Doctor ______________________________

Last Medical Exam______________________ Last Eye Health Exam______________________

Your Medical Insurance Company ______________________

Your Vision Insurance Company ______________________

What is your reason for today's eye examination? Please check all that apply:

___ blur at distance
___ blur at near
___ double vision
___ computer strain
___ diabetes
___ sunlight sensitivity
___ glaucoma
___ lazy eye
___ red eye
___ flashes/spots
___ dryness
___ high blood pressure
___ eye pain / discomfort
___ itching
___ macular degeneration
___ headaches
___ grittiness
___ other______________

Medical History

Are you currently being or have you ever been treated for any of the following health conditions?

___ diabetes
___ blood pressure
___ heart disease
___ strokes
___ thyroid problems
___ arthritis
___ allergies
___ STDs
___ HIV
___stomach problems
___ breathing problems
___ urinary problems
___ cancer
___ hearing loss
___ other______________________
___ depression/anxiety
___ kidney problems
___ skin conditions
___ headaches

Current Medications including over the counter: ______________________________

____

Are you allergic to any medications or foods? ___no ___yes If yes, list: ______________

____

Are you currently pregnant? ___ no ___ yes
Do you smoke or use tobacco products? ___ no ___ yes How much? __________
Do you drink alcohol? ___ no ___ yes
Do you have a history of drug use? ___ no ___ yes

Please check if anyone in your **family** (parents or siblings) has the following medical problems:

__________ diabetes
__________ arthritis
__________ glaucoma
__________ blindness
__________ high blood pressure
__________ sickle cell disease
__________ macular degeneration
__________ other ______________________
__________ heart disease
__________ retinal disease
__________ crossed eyes

Blank responses will be interpreted as a NO