PATIENT INFORMATION FORM

DATE____________________________ NAME____________________________________

ADDRESS_________________________ SEX M______ F___________________________

CITY____________________________ BIRTHDATE______________________________

STATE/ZIP________________________ S.S. #___________________________________

PHONE NUMBER ____

PRIMARY CARE MD ____

REASON FOR VISIT:____

CIRCLE ALL THAT APPLY TO YOU: GENERAL CHECK UP BROKEN GLASSES
CONTACTS BLURRED VISION DOUBLE VISION HEADACHES
SPOTS IN VISION PAINFUL EYE DRY EYE CONCUSSION
ITCHY EYE EYESTRAIN LIGHT FLASHES RED EYE
AMBLYOPIA (LAZY EYE) GLAUCOMA CATARACTS

GENERAL HEALTH: CIRCLE ALL THAT APPLY:
HIGH BLOOD PRESSURE DIABETES THYROID HIGH CHOLESTEROL OBESITY
ARTHRITIS SLEEP DISORDER DEPRESSION/ANXIETY HEPATITIS
BLEEDING DISORDER HIV/AIDS KIDNEY DISEASE LIVER DISEASE LUNG DISEASE
LUPUS MIGRAINES MULTIPLE SCLEROSIS STROKE ENVIRONMENTAL ALLERGIES
ASTHMA

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE______________________________

LIST FAMILY HISTORY OF ANY OF THE ABOVE CONDITIONS____________________

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ALCOHOL USAGE: NONE____SOCIALLY_____MODERATELY______ HEAVY_________

CIGARETTE SMOKING: NEVER________FORMER____________
CURRENT SMOKER DAILY USAGE: 1 PACK 1/2 PACK 5 CIGARETTES LESS THAN 5

CURRENT MEDICATIONS____

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MEDICATION ALLERGIES____

FOR PEDIATRIC PATIENTS: CURRENT WEIGHT______________ BIRTHWEIGHT_____________

ADHD/ADD: Y/ N AUTISM SPECTRUM: Y/ N PREMATURE?: Y/ N CROSSED EYES?: Y/ N

EMAIL IF AVAILABLE: