Dr. Muneer N. Hanna & Assoicates

Board Certified Optometric Physicians

		ertified Optometr		- -		
Patient Name				Today's Date/	/	_
Parent or Spouses Name	First	М		Male Fema	le	
Address				Soc. Sec. #	//	
City	State	Zip		Home phone ()_		
Birthdate/ Current Age				Work Phone ()		
Occupation Employer				Other phone ()		
Family members who are patients at our office				Email		
	F	Iealth Inforn	nation			
Reason for your visit			1	Have you or say of	ır blood =-	Intivas
Annual exam				Have you or any of your blood relatives ever had any of the following conditions?		
Eye Health Concern Contact Lens Evaluation				Diabetes	You	ranniy Member
				Diabetes		
Pre or Post Eye Surgery				II' 1 D1 1 1 D		
Interested in Discussing Refractive Eye Surgery or Contact Lens Options				High Blood Pressure		
Emergency				Heart/Vascular Disease		
Do you use a computer? Y N How many hours per day?						
When was your last eye exam?			_	Cancer/tumors		
Previous Eye Doctor's Name				Digestive Disorder		
Current Primary Doctor's Name				Breathing Disorder		
Current Medications				Breathing Disorder		
				Migraine Headaches		
				Immune Deficiency		
Allergies				Glaucoma		
Theights				Cataracts _		
II l. 1				Lazy Eye		
Have you ever had eye surgery or an eye injury? Y N Explain:				Blindness		
				Retinal Detachment _		
				Macular Degeneration Other		