# Dr. Muneer N. Hanna & Associates

Board Certified Optometric Physicians

Patient Name _____
Last First MI

Parent or Spouses Name _____

Address _____

City _____ State _____ Zip _____

Birthdate _____/_____/_____ Current Age _____

Occupation _____ Employer_____

Family members who are patients at our office _____

Today's Date _____/_____/_____

Male _____ Female_____

Soc. Sec. # _____/_____/_____

Home phone ( ) _____

Work Phone ( ) _____

Other phone ( ) _____

Email _____

## Health Information

Reason for your visit

_____ Annual exam
_____ Eye Health Concern
_____ Contact Lens Evaluation
_____ Pre or Post Eye Surgery
_____ Interested in Discussing Refractive Eye Surgery or Contact Lens Options
_____ Emergency

Do you use a computer? Y N How many hours per day? _____

When was your last eye exam? _____

Previous Eye Doctor's Name _____

Current Primary Doctor's Name _____

Current Medications

Allergies

Have you ever had eye surgery or an eye injury? Y N
Explain:

Have you or any of your blood relatives ever had any of the following conditions?

| Condition | You | Family Member |
|---|---|---|
| Diabetes | | |
| High Blood Pressure | | |
| Heart/Vascular Disease | | |
| Thyroid Disorder | | |
| Cancer/tumors | | |
| Digestive Disorder | | |
| Breathing Disorder | | |
| Migraine Headaches | | |
| Immune Deficiency | | |
| Glaucoma | | |
| Cataracts | | |
| Lazy Eye | | |
| Blindness | | |
| Retinal Detachment | | |
| Macular Degeneration | | |

Other