OPTOMETRIC CARE ASSOCIATES

Last Name _____ **First Name** _____

Patient's Occupation_____

Emergency Contact name _____ Phone Number_____

What is the primary reason for today's examination? _____

Who is your primary care physician? _____ What is your height? _____ Weight? _____

Do you have any health problems [ ] Y [ ] N If so, what are they? _____

_____

Have you had any surgeries? Y ( ) N ( ) Specify _____

Pregnant or Nursing Y ( ) N ( )

Are you diabetic? [ ] Y [ ] N How long have you been diabetic? _____ What was your last A1C? _____

Current medication list (if you have a written list with you, give it to the assistant to copy): _____

_____

Are you **allergic** to any medications? [ ] Y [ ] N If yes, please list: _____

Do you use any eyedrops? [ ] Y [ ] N If yes, please list: _____

Are you happy with your current glasses? [ ] Y [ ] N With your current contact lenses? [ ] Y [ ] N [ ] N/A

Smoking: Are you a current smoker? [ ] Y [ ] N Did you ever smoke in the past? [ ] Y [ ] N

Have you ever used narcotics or illegal drugs? [ ] Y [ ] N Drink alcohol? [ ] Y [ ] N

Have you ever had **Cataract** surgery? [ ] Y [ ] N **LASIK** [ ] R [ ] L Other eye surgery: _____

FAMILY HISTORY

Has anyone related to you by blood had any of the following conditions?

	CONDITION	WHO?		CONDITION	WHO?
[ ] Y [ ] N	Heart disease	_____	[ ] Y [ ] N	Cataracts	_____
[ ] Y [ ] N	Hypertension	_____	[ ] Y [ ] N	Glaucoma	_____
[ ] Y [ ] N	Diabetes	_____	[ ] Y [ ] N	Macular degen.	_____
[ ] Y [ ] N	Cancer	_____	[ ] Y [ ] N	Blindness	_____
[ ] Y [ ] N	Stroke	_____	[ ] Y [ ] N	Amblyopia "lazy eye"	_____
[ ] Y [ ] N	Other systemic dz	_____	[ ] Y [ ] N	Other ocular dz.	_____

Contact me by email: _____ Cell/Text: ( )_____-_____