PATIENT INFO

Mr. Mrs. Ms. Dr.	FIRST	LAST	DOB	AGE
ADDRESS		CITY/STATE	ZIP	
HOME PHONE	CELL PHONE	EMAIL		
OCCUPATION	EMPLOYER	WORK PHONE		
MEDICAL INSURANCE		VISION INSURANCE		
POLICY #	GROUP #	VISION POLICY #	GROUP #	
MEDICARE #		PATIENT SSN	PRIMARY SSN	

Reason for visit?____ Date of last exam?__________________

Do you wear glasses? Y N Age of glasses?____________ Any problems?______________________________

Do you wear contact lenses? Y N Age of lenses?_________ Any problems?______________________________

Are your lenses comfortable? Y N Type of lenses? ☐ Rigid ☐ Soft ☐ Extended Wear ☐ Other________________

PRIMARY CARE PHYSICIAN

NAME		PHONE	FAX
ADDRESS	CITY/STATE	ZIP	

This information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer. ☐ **Yes**, I would like to discuss my history information directly with the doctor.

EYE HISTORY (check all the apply)

☐ BLURRED VISION DISTANCE
☐ BLURRED VISION NEAR
☐ LOSS OF VISION
☐ LOSS OF SIDE VISION
☐ FLUCTUATING VISION
☐ DOUBLE VISION
☐ FLOATERS OR SPOTS IN VISION
☐ DISTORTED VISION/HALOS
☐ GLARE/LIGHT SENSITIVITY
☐ HEADACHES
☐ TIRED EYES
☐ EYE INFECTION
☐ EYE ALLERGIES
☐ REDNESS
☐ EYE PAIN/SORENESS
☐ BURNING
☐ ITCHING
☐ SANDY/GRITTY FEELING
☐ FOREIGN BODY SENSATION
☐ DRYNESS
☐ EXCESS TEARING/WATERING
☐ MUCOUS DISCHARGE
☐ AMBLYOPIA(LAZY EYE)
☐ DROOPING EYELID
☐ MACULAR DEGENERATION
☐ RETINAL DETACHMENT
☐ GLAUCOMA
☐ CATARACT
☐ DIABETIC RETINOPATHY
☐ COLOR BLINDNESS
☐ CROSSED EYES
OTHER____________________

GENERAL HEALTH CONDITION (check all that apply)

☐ HEART DISEASE
☐ CARDIOVASCULAR DISEASE
☐ HIGH BLOOD PRESSURE
☐ EARS, NOSE, THROAT
☐ RUNNY NOSE
☐ POST-NASAL DRIP
☐ CHRONIC COUGH
☐ SINUS CONGESTION
☐ CHRONIC BRONCHITIS
☐ EMPHYSEMA
☐ DRY THROAT/MOUTH
☐ THYROID DISEASE
☐ RESPIRATORY (ASTHMA)
☐ DIABETES
☐ KIDNEY
☐ ENDOCRINE
☐ WEIGHT LOSS
☐ GASTROINTESTINAL
☐ FEVER
☐ MUSCLES. BONES, JOINTS
☐ JOINT PAIN
☐ RHEUMATOID ARTHRITIS
☐ GENITALS, KIDNEY, BLADDER
☐ AIDS/HIV
☐ LUPUS
☐ SKIN
☐ ALLERGIES
☐ BLOOD/LYMPH
☐ BLEEDING PROBLEMS
☐ ANEMIA
☐ STROKE
☐ CANCER
☐ NEUROLOGICAL
☐ PSYCHIATRIC
☐ SKIN
☐ PREGNANT OR NURSING
☐ SMOKE CIGARETTES
OTHER____________________

FAMILY HISTORY (indicate parents, grandparents, siblings)

☐ BLINDNESS
☐ RETINAL DETACHMENT
☐ MACULAR DEGENERATION
☐ GLAUCOMA
☐ AMBLYOPIA (LAZY EYE)
☐ CATARACTS
☐ DIABETES
☐ HIGH BLOOD PRESSURE
☐ HEART DISEASE
☐ CANCER
☐ CROSSED EYES
☐ COLOR BLINDNESS
☐ KIDNEY DISEASE
☐ STROKE
☐ ARTHRITIS
☐ THYROID DISEASE
OTHER____________________

DRUG ALLERGIES
CURRENT MEDICATIONS (including over the counter and vitamins)