Patient Form

Personal/Family History	Yes	Who? (Blood Related Only)		Yes	Who? (Blood Related Only)
Arthritis			Multiple Sclerosis		
Cancer					
Diabetes			Crossed Eye		
Heart Disease			Lazy Eye		
High Blood Pressure			Macular Degeneration		
High Cholesterol			Retinal Detachment		
Thyroid Disease			Glaucoma		
Lupus			Cataracts		
Stroke			Blindness		
Kidney Disease					

EYE HISTORY

Date of Last Eye Exam _____ By whom? _____
Currently Wears Glasses? _____
Currently Wears Contact? _____ Brand of Contacts _____

Your reason(s) for visiting our office today: (please Check all that apply)

Comprehensive Exam	Headache	Blurred near vision	Blurred distance vision
Blurred computer vision	Night vision problems	Eye watering/tearing	Eyes itch
Eyes feel dry	Pain or discomfort in eyes	Flashes of lights	Floating spots in vision
Eyes feel tired	Light sensitivity	Double vision	Lost or broken glasses

Current Medications(prescription and over-the-counter) _____

_____

_____

Medication Allergies _____

Social History _____
Height _____ Weight _____ Are you Pregnant or nursing? _____
Have you ever smoked? _____ How long ago did you quit? _____
Do you drink? _____ How many daily? _____
Last Blood Pressure Reading? _____ Pulse _____

Patient Signature _____ **Date** _____
If patient is a minor what is the relationship? _____