Legal Name: _____ _____ Date of Birth: ____-___-____ Date: ___-_____-___
(First) (Middle) (Last) (Nickname)

Address: _____Apt/Lot _____ _____ _____ _____
(Street) (City) (State) (Zip code)

Home Phone: _____ Work: _____ Cell Phone: _____

Email Address: _____@_____ Social Security #: _____-_____-_____

Communication Preference (Circle one) Telephone or E-mail. Would you like text notifications /reminders? YES / NO

Preferred Language:_____ Race/Ethnicity: _____ Height: _____ Weight:_____

Do you smoke? _____ If yes, how much? _____ If Former, how long ago did you quit? _____

Marital status _____ Employer: _____ Occupation:_____

Emergency Contact information: Name:_____ Relation_____ Number_____

List all Current medications including prescriptions, Over-the-counter, vitamins, or eye drops:

_____ _____ _____ _____

_____ _____ _____ _____

- I do **NOT** take any Medications
- I will **PRESENT** my medication list (That we could copy)

Are you allergic to any Medications? Yes_____ No_____ If yes, please list: _____
Do you wear contact Lenses? Yes_____ No_____ If yes, what type? _____
Are you interested in contact lenses? Yes_____ No_____
Do you have these on a ***regular basis*** Have **you** or a **family** member had any of the following?

Without glasses or contacts?

			You	**Family**	**(relation to you)**
Blurred Vision	___	Diabetes	_____	_____	_____
Floaters in eyes	___	High Blood Pressure	_____	_____	_____
Flashes of light	___	Cardiac Trouble	_____	_____	_____
Burning Eyes	___	Breathing/Asthma	_____	_____	_____
Itching Eyes	___	Cancer	_____	_____	_____
Watery Eyes	___	Allergies	_____	_____	_____
Dry Eye	___	Thyroid disorder	_____	_____	_____
Eye Strain or pain	___	Macular Degen	_____	_____	_____
Headaches	___	Glaucoma	_____	_____	_____
		Lazy/crossed eye	_____	_____	_____
Years since last eye exam _____		Cataracts	_____	_____	_____

Last **Eye-** Doctor seen: _____ List any eye surgery you have had: _____
Primary Care Physician: _____