

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian (If applicable) \_\_\_\_\_

Address \_\_\_\_\_

Phone (cell) \_\_\_\_\_ Phone (home) \_\_\_\_\_ Date of Birth \_\_\_\_\_

Email \_\_\_\_\_ SSN \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Ocular History (please list any eye surgeries, diseases or other issues)

Do you wear contact lenses and/or want an exam for contact lenses (extra fee)?  Yes  No

Medical History--Please review and check any conditions in the following body systems.

**Constitutional/General**

- Developmental Delay
- Cancer

**Ear, Nose, Throat**

- Hearing Loss
- Sinusitis
- Dry Mouth

**Neurological**

- Multiple Sclerosis
- Epilepsy
- Dementia
- Migraine
- Autism Spectrum

**Psychiatric**

- Depression
- Attention Deficit
- Anxiety Disorder
- Bipolar Disorder

**Cardiovascular/Heart**

- High Blood Pressure
- Heart Disease
- Stroke

**Respiratory/Breathing**

- Smoker
- Asthma
- Emphysema
- COPD
- Sleep Apnea

**Gastrointestinal**

- Reflux
- Crohn's Disease

**Genitourinary**

- Kidney Disease
- Prostate
- HIV/AIDS
- STD

**Musc/Skeletal**

- Osteoarthritis
- Fibromyalgia
- Osteoporosis
- Gout

**Skin/Integ**

- Eczema
- Rosacea
- Herpes Zoster or Simplex

**Endocrine**

- Thyroid Dysfunction
- Diabetes T1 T2 Borderline

**Blood/Liver**

- Anemia
- Hepatitis
- High Cholesterol
- Leukemia

**Allergy/Immunologic**

- Lupus
- Rheumatoid Arthritis
- Allergies, environment or drug
- Sjogren's Syndrome

**Other Conditions not listed**

Current Medications. Please supply a list to our staff or write them here:

Medication Allergies  none \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Pharmacy \_\_\_\_\_

**Family History**

- Diabetes  High Blood Pressure  Glaucoma  Cataract
- Cancer  Macular Degeneration  Other \_\_\_\_\_

Do you:

Smoke – if yes, how much per day? \_\_\_\_\_

Drink alcohol – if yes, how much? \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_