Name: _____ Date: _____
Address: _____ Birth Date: _____
City, State, Zip: _____ Occupation: _____
Email Address: _____ Gender: M _____ F _____
Primary Phone: _____ Secondary Phone: _____

Chief Complaint:
Please briefly describe your reason for visit including any symptoms you are experiencing.

History of Present Illness:
Which eye has the problem? □Right □ Left □ Both
How severe is the problem □ Mild □ Moderate □ Severe
How long ago did the problem start? _____
Is the condition □New □ Ongoing □Recurring
Are there associated symptoms? □Headache □Blur □Flashes/Floaters □Burning/Itching □_____

Current **Medications**, **Eye Drops** and/or over-the-counter **Supplements**. Please list:

Allergies: (please list) _____
_____

Please list anything in **your** past history, family history or social history which would help us care for you:

Do **you** currently have any of these symptoms?
□ Blurred Vision □ Dry Eyes □ Flashes/Floaters □Mucous/Discharge
□ Burning/Itching □ Red Eyes □ Light Sensitivity □ Tearing/Watering

Do **you** have a history of the following eye conditions?
□ Cataract □Glaucoma □ Macular Degeneration □Retinal Detachment/Degeneration
□ Keratoconus □ Vision Loss □ Double Vision □ Crossed Eyes/Lazy Eye
□ Eye Surgery □ Eye Injury □ Vision Therapy/Patching □ Other _____
Has anyone in your **family** had any of the above conditions? (please list)
_____
_____

Do **you** have a history of any of the following conditions?
□ Vascular Disease □ Migraines □ Neurological Disorders (specify) _____
□ Depression □ Anxiety Disorder □ Other psychiatric (specify) _____
□ Hypertension □ Heart Disease □ Cancer (specify) _____
□ Asthma □ Emphysema □ Gastrointestinal (specify) _____
□ Thyroid Problems□ Anemia □ Diabetes (Type 1 or Type 2) _____
□ Kidney Disease □ Arthritis □ Other (specify) _____
□ Ulcer □ Rheumatoid
Has anyone in your **family** had any of the above conditions? (please list)
_____
_____

Are you a current smoker? □Yes □ No Are you a former smoker? □Yes □ No
Are you pregnant or nursing? □ Yes □ No Do you wear sunglasses? □ Yes □ No

When was your last eye exam? _____ Are you a previous patient of ours? □ Yes □ No
Have you previously worn contacts? □ Yes □ No Are you interested in contacts? □ Yes □ No