PATIENT INFORMATION

Single / Married / Divorced — First Name	Last Name	MI	Birthdate	Age

Mailing Address — City — State — Zip	Home / Cell Phone	Work Phone

Occupation/Employer	Social Security # (Patients With Insurance Only)	Vision / Medical Insurance

PATIENT MEDICAL / SOCIAL HISTORY

Date of last **EYE EXAM**: _____ Have your eyes been Dilated before? [] No [] Yes When? _____

Have you been examined at our office before? [] No [] Yes Do you wear contact lenses? [] No [] Yes

Do you wear glasses? [] No [] Yes If yes, For distance? [] For reading? [] For computer? []

Do you use/work with a computer? [] No [] Yes, _____ hours / day.

Date of last **PHYSICAL EXAM**: _____ Name of your **PHYSICIAN**: _____

List any **MEDICATIONS** you take: _____

Are you **ALLERGIC** to any medication? [] No [] Yes If yes, list:_____

List any **EYE** diseases, injuries, or surgeries: (i.e. glaucoma, cataracts, retinal detachment, crossed eyes or macular degeneration)

_____

_____

Are you pregnant? [] No [] Yes Do you smoke?_____Use alcohol?_____

What sports and hobbies do you enjoy? _____

PATIENT HISTORY - REVIEW OF SYSTEMS

Do you currently, or have you ever had any problems in the following areas:

	No	Yes	When?		No	Yes	When?		No	Yes	When?
Flashes/Floaters in Vision	[]	[]	_____	Eye Pain or Soreness	[]	[]	_____	Diabetes	[]	[]	_____
Tired Eyes	[]	[]	_____	Chronic Lid Infection	[]	[]	_____	Heart Pain	[]	[]	_____
Loss of Vision	[]	[]	_____	Sties or Chalazion	[]	[]	_____	High Blood Pressure	[]	[]	_____
Blurred Vision	[]	[]	_____					Vascular Disease	[]	[]	_____
Distorted Vision/Halos	[]	[]	_____	Fever or weight loss	[]	[]	_____	Cancer	[]	[]	_____
Loss of Side Vision	[]	[]	_____	Skin conditions	[]	[]	_____	Asthma	[]	[]	_____
Double Vision	[]	[]	_____	Headaches	[]	[]	_____	Emphysema	[]	[]	_____
Dryness	[]	[]	_____	Migraines	[]	[]	_____	Gastrointestinal	[]	[]	_____
Mucous Discharge	[]	[]	_____	Seizures	[]	[]	_____	Kidney/Bladder	[]	[]	_____
Redness	[]	[]	_____	Allergies/Hay Fever	[]	[]	_____	Rheumatoid Arthritis	[]	[]	_____
Sandy or Gritty Feeling	[]	[]	_____	Sinus Congestion	[]	[]	_____	Muscle Pain	[]	[]	_____
Itching	[]	[]	_____	Runny Nose	[]	[]	_____	Joint Pain	[]	[]	_____
Burning	[]	[]	_____	Post-Nasal Drip	[]	[]	_____	Anemia	[]	[]	_____
Excess Tearing/Watering	[]	[]	_____	Chronic Cough	[]	[]	_____	Bleeding Problems	[]	[]	_____
Glare/Light Sensitivity	[]	[]	_____	Dry Throat/Mouth	[]	[]	_____	Thyroid/Glandular	[]	[]	_____
Foreign Body Sensation	[]	[]	_____	Allergic/Immunologic	[]	[]	_____	Psychiatric	[]	[]	_____
									[]	[]	

FAMILY HISTORY

Please note any family history (parents, grandparents, siblings, children; living or deceased):

	No	Yes	?	Relationship to you		No	Yes	?	Relationship to you
Blindness	[]	[]	[]	_____	Cancer	[]	[]	[]	_____
Cataract	[]	[]	[]	_____	Diabetes	[]	[]	[]	_____
Crossed Eyes	[]	[]	[]	_____	Heart Disease	[]	[]	[]	_____
Glaucoma	[]	[]	[]	_____	High Blood Pressure	[]	[]	[]	_____
Macular Degeneration	[]	[]	[]	_____	Kidney Disease	[]	[]	[]	_____
Retinal Disease	[]	[]	[]	_____	Thyroid Disease	[]	[]	[]	_____
Arthritis	[]	[]	[]	_____	Other _____	[]	[]	[]	_____