Paris Optical

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Patient Information	Today's Date:_____
Name: **Last** **First** **MI**	**Date of Birth:**
Address:	**Social Security #:**
City:	**Zip:**
Occupation:	**Employer:**
Home #:	**Work #:**
Cell #:	**Email Address:**

Medical History Form	
Reason for today's visit:	Contact lense wearer: Y or N **If YES:**
Date of last vision exam:	Do you sleep in lenses? Y or N Brand / Power?:
Do you have headaches, flashes of light, or floaters?	If glasses wearer, how old is your current prescription?
Primary Care Physician/ Date of last visit:	What pharmacy do you use?
List **current medications** (Rx or OTC):	List any medication you are **allergic** to:

Your General Health **Have you ever had or do you currently have:**	**Family Health History** **Has anyone in your family had:**
☐ Allergies ☐ Arthritis ☐ Cancer - Type:_____ ☐ Diabetes ☐ Drug Reaction ☐ Eye Disease ☐ Eye Surgery ☐ Gastrointestinal Disease ☐ Headaches ☐ High Blood Pressure ☐ Kidney Disease ☐ Thyroid Disease ☐ Respiratory Disease ☐ Other, please list:_____	☐ Blindness ☐ Cataracts ☐ Crossed eyes ☐ Diabetes ☐ Glaucoma ☐ Lazy Eye ☐ Macular Degeneration ☐ Other Do you: ☐ Smoke ☐ Consume Alcohol

If the patient is a minor, please complete the following questions.

Parent/Guardian Name:	Date of Birth:
Employer:	SS #: