Patient Name: DOB:

What is the reason for your visit today? (Please Circle)

Updating Glasses Prescription	Eyestrain
Updating Contact Lens Prescription	Poor Night Vision
Blurry Vision with No Prior Glasses Use	Floaters
Medical Visit (please explain in space below**)	Dry Eyes

**

Current Health History (Please Circle)

Ear/Nose/Throat	Gastric/Intestinal	Neurological
Allergies/Hay Fever	Chron's Colitis	Balance Issues
Sleep Apnea	GERD	Dementia
Sinus Problems	Jaundice	Vertigo
Chonic Cough	**Muscle/Skeletal**	Seizures
Cardiovascular	Arthritis	MS
High Blood Pressure	Gout	Headaches/Migraines
High Cholesterol	Fibromyalgia	**Psychological**
Heart Issues	**Endocrine**	Anxiety
Stroke/TIA	Type 1 Diabetes	Panic Disorder
Respiratory	Type 2 Diabetes	PTSD
Asthma	Hypothyroid	Depression
Chronic Bronchitis	Hyperthyroid	Schizophrenia
Emphysema	**Skin**	**Blood/Lymph**
TB	Acne	Anemia
Smoker	Eczema	CMV
Genital/Urinary	Psoriasis	**Immune**
Kidney Problems	Rosacea	Lupus
HIV		
STD		

Are you Currently Pregnant?
□ Yes How many mo.? _________
□ No

Are you Currently Nursing?
□ Yes
□ No

Have YOU had any previous eye injuries? □ Yes Please Explain Below** □ No

**

List Any Drug Allergies

List Any Major Surgeries/Injuries

List Current Medications and Dose (or Provide our Staff with a Printed List)

Immediate Family Eye History (Please Circle & Specify Who)

Glaucoma	Retinal Diseases	Cataracts
Macular Degeneration	Retinal Tear/Detachment	Amblyopia (Lazy Eye)

Family Medical History (Please Circle & Specify Who)

Diabetes	High Blood Pressure	Heart Disease
Thyroid Issues	Cancer	

Social History

Height: ________ft _______in.
Weight: _______lbs

Tobacco Use: □ None □ Former □ Current
Alcohol Use: □ None □ Occasional □ Social □ Daily

Signature: ______________________________ Date: ____________