Name: _____ Date: _____

Address: _____ Phone: _____

_____ Mobile Phone: _____

Birth Date: _____ Social Security #: _____ Email: _____

Name of Primary Care Doctor: _____ Last Eye Exam: _____

Doctor's Phone: _____ Last Medical Exam: _____

Emergency Contact:

Name: _____ Relation: _____

Address: _____ Phone: _____

_____

Mother's Maiden Name: _____

Medical History:

Do you have any allergies to any medications? ___ No ___ Yes If yes, explain: _____

_____

List any medications you take (including oral contraceptives, aspirin, over the counter medications and home remedies):

_____

List all major injuries, surgeries, and/or hospitalizations you have had: _____

_____

Circle any of the following that **you** have had: crossed eyes lazy eye dropping eyelid prominent eyes

glaucoma retinal disease cataracts eye infections/injuries

Are you pregnant or nursing? ___ No ___ Yes

Do you wear glasses? ___ No ___ Yes If yes, how old is your present pair of lenses? _____

Do you wear contact lenses? ___ No ___ Yes If yes, how old is your present pair of lenses? _____

Type of contact lenses: ___ Hard ___ Soft ___ Extended wear ___ Other _____

Are they comfortable? ___ No ___ Yes

Have you had vision surgery? ___ No ___ Yes If yes, which? RK PRK LASIK INTACS Ortho-K other _____

Social History:

Do you drive? ___ No ___ Yes If yes, any visual difficulties? _____

Do you use tobacco products? ___ No ___ Yes If yes, type/amount/how long? _____ Former/Never

Do you drink alcohol? ___ No ___ Yes If yes, type/amount/how long? _____

Do you use illegal drugs? ___ No ___ Yes If yes, type/amount/how long? _____

Have you ever been exposed to or infected with: ___ Gonorrhea ___ Hepatitis ___ HIV ___ Syphilis ___ Tuberculosis

Occupation: _____ Employer: _____

*** PLEASE COMPLETE OTHER SIDE ***

Review of Systems:

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

	NO	YES	?
CONSTITUTIONAL			
Fever, Weight Loss / Gain	___	___	___
INTEGUMENTARY (skin)	___	___	___
NEUROLOGICAL			
Headaches/Migraines	___	___	___
Seizures	___	___	___
EYES			
Blurry Vision	___	___	___
Mucous Discharge	___	___	___
Itching	___	___	___
Burning	___	___	___
Excessive Tearing	___	___	___
Redness	___	___	___
Dryness	___	___	___
Sandy or Gritty Feeling	___	___	___
Foreign Body Sensation	___	___	___
Glare / Light Sensitivity	___	___	___
Eye Pain or Soreness	___	___	___
Chronic Infection of Eyelid	___	___	___
Floaters / Flashes in Vision	___	___	___
Eye Strain / Tired Eyes	___	___	___
Loss of Vision	___	___	___
Double Vision	___	___	___
ENDOCRINE			
Thyroid / Other Glands	___	___	___
Diabetes	___	___	___

	NO	YES	?
EARS, NOSE, MOUTH, THROAT			
Allergies / Hay Fever	___	___	___
Sinus Congestion	___	___	___
Runny Nose	___	___	___
Dry Mouth / Throat	___	___	___
RESPIRATORY			
Asthma	___	___	___
Emphysema	___	___	___
VASCULAR / CARDIOVASCULAR			
Chest Pain	___	___	___
Vascular Disease	___	___	___
High Blood Pressure	___	___	___
High Cholesterol	___	___	___
GASTROINTESTINAL			
Diarrhea	___	___	___
Constipation	___	___	___
GENITOURINARY			
Genitals / Kidney / Bladder	___	___	___
MUSCULOSKELETAL			
Arthritis / Joint Pain	___	___	___
LYMPHATIC / HEMATOLOGIC			
Anemia	___	___	___
Bleeding Problems	___	___	___
ALLERGIC / IMMUNOLOGIC	___	___	___
PSYCHIATRIC			
Depression / Anxiety	___	___	___

Family History:

Please note any family history (**parents, grandparents, siblings, children**; living or deceased) for the following conditions:

DISEASE/CONDITION	NO	YES	?	RELATIONSHIP TO YOU
Glaucoma	___	___	___	_____
Macular Degeneration	___	___	___	_____
Retinal Disease	___	___	___	_____
Blindness	___	___	___	_____
Cataract	___	___	___	_____
Crossed Eyes	___	___	___	_____
Arthritis	___	___	___	_____
Cancer	___	___	___	_____
Diabetes	___	___	___	_____
Heart Disease	___	___	___	_____
High Blood Pressure	___	___	___	_____
Kidney Disease	___	___	___	_____
Lupus	___	___	___	_____
Thyroid Disease	___	___	___	_____
Other	___	___	___	_____

How did you hear about us? _____