Patient Information (Please Print)

Last Name	First Name and Middle Initial	Sex M F	Birthdate	Social Security Number

Home Address	City	State Zip	Home Phone	Contact Number

Employer	Occupation	Referred by	single married

Vision Insurance	Vision Insurance ID#	Policy Holder's Name and DOB (if different from above)

Health Insurance	Health Insurance ID#	Policy Holder's Name and DOB (if different from above)

Date of Last Eye Exam	email address

Medical Information

What is your general health? _____ Do you smoke? Yes/No

Diabetes Yes/No Type _____ Date of Diagnosis _____

Do you have problems with any of these systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lymph	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Skin	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Eyes	Yes/No	Mental	Yes/No

Current Medications _____

_____

Allergies to Medication Yes/No Which? _____

Other health problems _____

Primary care doctor _____

Family History

High blood pressure	Yes/No	Relation _____	Macular degeneration	Yes/No	Relation _____
Diabetes	Yes/No	Relation _____	Retinal detachment	Yes/No	Relation _____
Glaucoma	Yes/No	Relation _____	Cataracts	Yes/No	Relation _____

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Have you had an eye injury? Yes/No Kind _____ Date _____

Do you have glaucoma?	Yes/No	Cataracts?	Yes/No	Dry eyes?	Yes/No
Macular degeneration?	Yes/No	Blurred vision?	Yes/No	Retinal detachment?	Yes/No
Do you wear glasses?	Yes/No				

Do you wear contact lenses? Yes/No Type _____

Do you sleep in your contacts? Yes/No Nights per week _____

What do you use to clean your contacts? _____

How many hours do you work on a computer each day? _____ hours per day

What sports and hobbies do you enjoy? _____

Doctor Use Only

Reviewed by _____ Date _____ oriented to time, place, person Y N

Reviewed by _____ Date _____ mood and effect normal Y N