

**Patient Information**

Name \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip Code \_\_\_\_\_  
Home Phone: ( ) \_\_\_\_\_  
Cell Phone: ( ) \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Employer \_\_\_\_\_  
Occupation \_\_\_\_\_  
Marital Status  Single  Divorced  
 Married Spouse's Name \_\_\_\_\_  
 Widowed  
Did someone refer you to our office?  Yes  No  
Who can we thank? \_\_\_\_\_  
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Do we treat any family members?  Yes  No  
Who? \_\_\_\_\_

**Medical History**

Name of Medical Doctor \_\_\_\_\_  
Please list all prescription medications you currently take: \_\_\_\_\_

Do you have any drug allergies?  Yes  No If yes, please list: \_\_\_\_\_  
Are you pregnant or nursing?  Yes  No Are you a smoker?  Yes  No  
Do you drink alcoholic beverages? Yes No Do you drive? Yes No

*Please check all that apply:*

- Weight Loss/Gain  Allergies  Diabetes
- Heart Attack Year? \_\_\_\_\_  Stroke Year? \_\_\_\_\_  High Blood Pressure
- Asthma  Emphysema  Stomach Problems
- Kidney/Bladder Problems  Rheumatoid Arthritis  Joint Replacement
- Skin Condition  Headaches  Seizures
- Psychiatric Care  Thyroid Problems  Anemia
- Immune Deficiency  Cancer  Other \_\_\_\_\_

**Family History (parents, grandparents, siblings, children)**

- Cataract  Glaucoma  Macular Degeneration
- Retinal Detachment  Crossed Eyes  Diabetes

**Ocular History**

- Lazy/crossed eye  Drooping Eyelid  Glaucoma
- Retinal Disease  Cataract  Eye Injury
- Blurred Vision  Dryness  Mucous Discharge
- Redness  Sandy/Gritty Feeling  Itching
- Burning  Foreign Body Sensation  Watering
- Light Sensitivity  Eye Pain  Flashes of Light
- Black Spots (Floaters)

Name of your last eye doctor \_\_\_\_\_ How long since your last exam? \_\_\_\_\_  
Do you wear glasses?  Yes  No If yes, how old is your current pair? \_\_\_\_\_  
Do you wear contact lenses?  Yes  No  
Are you interested in being examined for contact lenses today?  Yes  No  
What is the reason for your examination today? \_\_\_\_\_

*By signing, I agree that the above information is correct and true.*

X \_\_\_\_\_ Date \_\_\_\_\_

