



Last Name: _____ First Name: _____ MI: _____
Address: _____ City: _____ State: _____ Zip: _____
Telephone: (Cell) _____ (Home) _____ (Work) _____
Email: _____

Communication Preference (circle one): TEXT EMAIL PHONE

Marital Status (circle one): Married Divorced Single Widowed

SSN: _____ DOB: ____/____/____ GENDER: M / F

Occupation: _____ Employer: _____

Emergency Contact/Telephone Number: _____

Date of Last eye exam: _____ Today's Date: ____/____/____

Medical Information

Do you have problems with any of these systems? (Please circle all that apply)

Allergic /Immunologic	Y/N	Integumentary(skin)	Y/N	Mental	Y/N
Blood/Lymphatic	Y/N	Endocrine(glands)	Y/N	Musculoskeletal	Y/N
Cardiovascular	Y/N	Gastrointestinal	Y/N	Nervous	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Respiratory	Y/N

Please Explain: _____

Please answer all that apply:

Diabetes Y/N Type: _____ Date of Diagnosis: _____

Allergies Y/N Allergic to what? _____ Type of Reaction? _____

Current Medications: _____

Have you had any operations? Y/N What Type: _____

Do you use alcohol? Y/N Amount: _____

Do you use other substances? Y/N Type/Amount: _____

Name of family doctor? _____

Family History: Please answer if any of your family members have these problems.

High Blood Pressure	Y/N	Relation _____	Macular Degeneration	Y/N	Relation _____
Diabetes	Y/N	Relation _____	Retinal Detachment	Y/N	Relation _____
Glaucoma	Y/N	Relation _____	Cataracts	Y/N	Relation _____
Other eye conditions	Y/N	Relation _____			

Personal Eye Information

Have you had any eye operations? Y/N Type: _____ Date: _____

Have you had an eye injury? Y/N Type: _____ Date: _____

Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurry Vision? Y/N

Other eye problems? Type: _____

Do you wear glasses? Y/N Contact Lenses? Y/N Type/Brand: _____

Additional Information: _____

How did you hear about our office? Patient: _____ INTERNET COMMERCIAL OTHER: _____

Optometric Physician's Initials (To be completed by doctor): _____