Welcome to Our Office!

Thank you for choosing our practice for your eye care needs. Please take a few minutes to answer the following questions so that we may better assist you with your health care needs.

Patient Information

Name: _____ Birth date __ '__ '__
SSN: _____ Sex: Male or Female
Home Number: _____ Cell Number: _____
Email _____
Contact Preference: Email Cell Home

Address: _____ City/State/Zip: _____
Occupation_____
Marital Status: Single Married Divorced Widow Separated

Emergency Contact: _____
Phone: _____ Relationship: _____

Eye Health History

Do you experience any of these problems with your eyes?
(CIRCLE ALL THAT APPLIES)

BLOODSHOT EYES	BLURRED VISION	BURNING EYES	CATARACTS
POOR COLOR VISION	CROSSED EYES	DISCHARGE	DIZZINESS
DOUBLE VISION	DRY EYES	EYE INFECTION	EYE INJURY
EYE STRAIN	FAINTING	FLOATERS	GLAUCOMA
ITCHING EYES	LIGHT SENSITIVITY	MIGRAINES	RED EYES
POOR NIGHT VISION	HALOS OR FLASHES	TWITCHING	WATERING EYES

Previous Eye Doctor: _____
Date of Last Exam: _____

Do you wear glasses? Yes or No How often? _____
Do you wear Contact Lenses: Yes or No How Often? _____

FAMILY DR NAME: _____DATE OF LAST VISIT_____

CIRCLE YES OR NO TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING AND A CIRCLE IF A BLOOD RELATIVE HAS HAD ANY OF THE FOLLOWING PROBLEMS:

	YOURSELF	FAMILY		YOURSELF	FAMILY
AIDS/HIV	YES NO	YES NO	HEPATITIS (TYPE_____)	YES NO	YES NO
ARTHRITIS	YES NO	YES NO	HIGH BLOOD PRESSURE	YES NO	YES NO
ARTIFICAL HEART VALVE	YES NO	YES NO	KIDNEY DISEASE	YES NO	YES NO
ARTIFICAL JOINTS	YES NO	YES NO	LAZY EYE	YES NO	YES NO
ASTHMA	YES NO	YES NO	LUPUS	YES NO	YES NO
BLEEDING	YES NO	YES NO	MIGRAINE HEADACHES	YES NO	YES NO
BLINDNESS	YES NO	YES NO	PACEMAKER	YES NO	YES NO
CANCER	YES NO	YES NO	POOR COLOR VISION	YES NO	YES NO
CATARACTS	YES NO	YES NO	RETINAL DISEASE	YES NO	YES NO
CHEMICAL DEPENDENCY	YES NO	YES NO	RHEUMATIC FEVER	YES NO	YES NO
DIABETES	YES NO	YES NO	SHINGLES	YES NO	YES NO
DRUG SENSITIVITY	YES NO	YES NO	SKIN CONDITIONS	YES NO	YES NO
EMPHYSEMA	YES NO	YES NO	STROKE	YES NO	YES NO
EPILEPSY	YES NO	YES NO	THYROID CONDITIONS	YES NO	YES NO
EYE SURGERY	YES NO	YES NO	TUBERCULOSIS	YES NO	YES NO
GLAUCOMA	YES NO	YES NO	TURNED EYE	YES NO	YES NO
HAY FEVER	YES NO	YES NO			
HEART CONDITIONS	YES NO	YES NO			

ARE YOU PREGNANT? _____ NUMBER OF CHILDREN: _____

DO YOU SMOKE? _____ DO YOU DRINK: _____

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING EYE DROPS:

_____

_____

_____

_____

LIST ANY ALLERGIES TO MEDICATIONS OR ANY OTHER SUBSTANCES:

_____

_____

WHICH PHARMACY DO YOU CURRENTLY USE: _____