Patient Information Date ____/____/____

Name ______________________________________ ☐ Male ☐ Female Birthdate ____/____/____

Mailing Address ______________________________ City______________________ State ______Zip____________

Primary Phone ( ) ____________________home/cell/work Alternate Phone ( )________________home/cell/work

Email Address: ____________________________________ Employer/Occupation ________________________

Please circle the way(s) you prefer to be contacted: phone / mail / Email

Emergency Contact Name _______________________Phone # ( ) ______________Relationship____________

If you are a new patient	**Are you going to be using insurance for the eye exam?**
When was your last eye exam? __________________ Where was your last eye exam? __________________ How did you hear about us? ______________________	☐ No ☐ Yes

***Reason for Today's visit?____

Do you wear GLASSES? ☐None ☐Single Vision ☐Bifocal ☐ Trifocal ☐No Line Progressive ☐Rx sunglasses ☐Readers

Do you wear CONTACTS? ☐No ☐Yes

Patient Medical History (*circle yes or no, Please answer all*)

Diabetes	Yes No	**General Health**	
High Blood Pressure	Yes No	Medication Allergies	Yes No
Respiratory/Asthma Problems	Yes No	Pregnant or Nursing	Yes No
Thyroid Problems	Yes No	Alcohol use	Yes No
Cardiovascular Problems	Yes No	Tobacco use	Yes No
Musculoskeletal Problems	Yes No		
Neurological Problems	Yes No	Primary Care Dr. Name or Clinic	________________________
Psychiatric Problems	Yes No		
Ear-Nose-Throat Problems	Yes No		
Gastrointestinal Problems	Yes No	**Eyes**	Do you or a relative have:
Renal/Kidney Problems	Yes No		
Genitourinary Problems	Yes No	Crossed/Lazy Eye	Yes No who? __________
Immunologic Problems	Yes No	Glaucoma	Yes No who? __________
Hormonal/Endocrine Problems	Yes No	Cataracts	Yes No who? __________
Lymphatic Problems	Yes No	Macular Degeneration	Yes No who? __________
Hematological (blood)	Yes No	Retinal Disease	Yes No who? __________
Problems	Yes No	EYE surgery or injury	Yes No who? __________
Cancer	Yes No	Other	Yes No ______________
Allergies	Yes No		

Please explain above problems: ____

____

Please list ALL medications and eye drops you are currently using: ☐None

____

I verify that the above information is correct to the best of my knowledge.

______________________________ ________________ __________________

Signature Date Relationship to Patient