Name_____ Date of Birth_____ Today's Date_____
Address_____
City_____ State_____ Zip_____

Primary Phone _____ home work cell
Secondary Phone_____ home work cell
Email Address_____
Preferred Contact Method: cell text email other_____

Other individual's who may access my information_____

Occupation/Employer_____

Primary Care Physician_____

Date of Last **Eye** Exam and Location if a ***new*** patient_____

Contact Lens Brand and Prescription if a ***new*** patient: Right_____
Left _____
Contact Lens Solution Name _____

Reason for today's visit:_____

If you are a ***new*** patient how did you hear about our office?
_____

MEDICAL HISTORY

*Check **ONLY** the conditions that apply to you or your **Immediate Family***

	Self	Family
Glaucoma	____	____
Macular Degeneration	____	____
Retinal Detachment	____	____
Cataract Surgery	____	____
Laser Surgery(Lasik/PRK)	____	____
Lazy/Crossed Eye	____	____
Blindness	____	____
Eye Injury	____	____
Other Eye Conditions	____	____
Cancer	____	____
Developmental Disorders	____	____
Ears/Nose/Throat Problems	____	____
Epilepsy/Seizures	____	____
Stroke	____	____
Headaches or Migraines	____	
Brain Tumor	____	____
Depression	____	
Bipolar Disorder	____	
Anxiety Disorder	____	
Attention Deficit Disorder	____	
Heart Problems	____	____
High Blood Pressure	____	____
Breathing/Lung Conditions	____	____
Sleep Apnea	____	____
Stomach/Intestinal Problems	____	____
Urinary/Kidney Problems	____	____

	Self	Family
HIV/AIDS	____	
Gonorrhea or Syphilis	____	
Hepatitis A B C	____	
Arthritis	____	____
Fibromyalgia	____	____
Ankylosing Spondylitis	____	____
Muscular Dystrophy	____	____
Herpes Simplex/Cold Sores	____	____
Herpes Zoster/Shingles	____	____
Skin Problems	____	____
Diabetes Type I II	____	____
Thyroid Problems	____	____
Blood Disorders (Anemia,etc)	____	____
High Cholesterol	____	____
Environmental Allergies	____	
Lupus	____	
Autoimmune Disease	____	
Currently Pregnant	____	
Currently Breast Feeding	____	
Do you use Tobacco	____	
Do you drink Alcohol	____	

Other Conditions_____

_____

Surgeries_____

_____

_____

Medications:_____

_____

_____

_____

Allergies:_____

_____

_____

_____