

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_

Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ SS # \_\_\_\_\_ Email \_\_\_\_\_

PHYSICAL ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ST. \_\_\_\_\_ ZIP \_\_\_\_\_

Married / single / divorced / minor / other (Circle one) Medical Insurance?  Yes or  No Family Doctor \_\_\_\_\_

If minor: Responsible party \_\_\_\_\_ SS # \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Date of last eye exam \_\_\_\_\_ Doctor \_\_\_\_\_ Glasses? Y / N Contacts? Y / N Other Treatment? \_\_\_\_\_

Reason for visit  Blurry vision  Double vision  Tearing  Eye discomfort  Vision loss  Red/irritated  Other

**Why did you select our practice?**  Word of mouth  Referred by friend/relative  Referred by doctor  Yellow pages  other

**I have been diagnosed with or treated for (CIRCLE ALL THAT APPLY)**

Cataract Glaucoma Macular Degeneration Other \_\_\_\_\_ Eye surgeries

**I have a family member or relative diagnosed with or treated for (CIRCLE ALL THAT APPLY)**

Cataract Glaucoma Macular Degeneration Other \_\_\_\_\_ Hypertension Diabetes Eye Problems

Occupation or School Grade \_\_\_\_\_ Name and address of employment: \_\_\_\_\_

***Please check any medical problems listed below or check none if no problems with that system***

CONSTITUTIONAL None \_\_\_\_  
 developmental disability  
 weight loss  peri-birth problems  
 fever  premature  
 fatigue  
 trauma  
 other

GASTROINTESTINAL None \_\_\_\_  
 Crohn's  
 colitis  
 ulcer  
 digestive/acid reflux  
 other

NEUROLOGICAL None \_\_\_\_  
 multiple sclerosis  
 epilepsy  dyslexia  
 migraines  learning disabilities  
 other

PSYCHIATRIC None \_\_\_\_  
 depression  ADD/ADHD  
 panic disorder  
 schizophrenia  
 other

EARS, NOSE, THROAT None \_\_\_\_  
 upper respiratory tract infection  
 other

ALLERGIC None \_\_\_\_  
 allergy / atopy  
 rheumatoid arthritis  
 lupus  
 other

ENDOCRINE None \_\_\_\_  
 non-insulin dependent diabetes  
 insulin-dependent diabetes  
 thyroid dysfunction  
 hormonal dysfunction  
 other

CARDIOVASCULAR None \_\_\_\_  
 heart disease  
 hypertension  
 stroke  
 vascular disease  
 other

MUSKULOSKELETAL None \_\_\_\_  
 fibromyalgia  
 muscular dystrophy  
 arthritis/osteoarthritis  
 ankylosing spondylitis  
 other

HEMATOLOGICAL None \_\_\_\_  
 history of large volume blood loss  
 leukemia  Hepatitis C  
 anemia  HIV  
 other

RESPIRATORY None \_\_\_\_  
 smoker or recent ex-smoker  
 asthma  Tuberculosis  
 bronchitis  
 emphysema  
 other

INTEGUMENTARY None \_\_\_\_  
 eczema  
 rosacea  
 psoriasis  
 other

GENITOURINARY None \_\_\_\_  
 urinary tract infection  
 kidney ailments  
 STD – herpes, chlamydia  
 other

**LIST OF MEDICINES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medicine allergies? \_\_\_\_\_

Doctors initials \_\_\_\_\_