LAST NAME: _____ FIRST NAME _____ MI ___ BIRTH DATE ____-___-_____

ADDRESS: _____ CITY _____ ST _____ ZIP _____

TEL.(H) (_____) _____ TEL. (W) (_____) _____ OCCUPATION _____

GENDER: ☐ M ☐ F MARITAL STATUS: ☐ S ☐M ☐D ☐ W REFERRED BY _____

CONTACT PERSON _____ RELATIONSHIP TO PT _____ TEL (_____)_____

MAIN EYE PROBLEM: _____ FIRST BEGIN ? _____

OTHER EYE CONDITION (S):_____ DO YOU WEAR: ☐ GLASSES ☐ CONTACT LENS ☐ NONE

_____ Are you interested in Contact Lenses?_____

MEDICAL CONDITION (S):

Y	N	
☐	☐	HIGH BLOOD PRESSURE
☐	☐	DIABETES
☐	☐	CARDIOVASCULAR
☐	☐	ASTHMA
☐	☐	THYROID
__		OTHER_____

FAMILY HISTORY:

Y	N	
☐	☐	GLAUCOMA
☐	☐	BLINDNESS _____
☐	☐	CATARACT _____
☐	☐	MACULA DEGENERATION
☐	☐	DIABETES
__		OTHER_____

***DRUG ALLERGIES: _____

_____

EYE MEDS: _____

_____

OTHER MEDS_____

_____

PRIOR SURGERIES: _____

DO YOU SMOKE? ☐ Yes ☐ No ☐ Quit DO YOU DRINK? ☐ Yes ☐ No HOBBY: _____

How much? _____Since: _____ How often? _____ COMPUTER WORK ?_____

HEALTH INSURANCE: _____ NAME ON POLICY: _____

VISION BENEFITS _____ LAST ROUTINE EYE EXAM _____

POLICY # _____ GRP # _____ ID #_____

MEDICARE # _____ SOCIAL SECURITY # _____ - _____ - _____