Patient Information & Medical History

Name: ________________________ Date of birth: ________________________

Parent or Guardian if under 19: ________________________

Email: ________________________ Communication Preference: ________________________

Address: ________________________ City/State: ____________ Zip: ________

Phone: Home ____________ Work ____________ Cell ____________ Text OK? ____

Employer/School: ____________ Occupation/Grade: ____________ SSN _____—_____—_____

Medical Insurance: ________________________ Vision Insurance: ________________________

Medications: ____

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Medication Allergies? Y N Please list: ________________________

Patient/Family History	Self	Family
Glaucoma	Y	F M S B
Lazy Eye	Y	F M S B
Macular Degeneration	Y	F M S B
Retinal Disease	Y	F M S B
High Cholesterol	Y	F M S B
High Blood Pressure	Y	F M S B
Diabetes	Y	F M S B

Patient Medical History	Yes/No	Explain
Ear, Nose, Throat	Y N	
Cardiovascular (eg. heart)	Y N	
Gastrointestinal (eg. IBS, reflux)	Y N	
Genitourinary	Y N	
Respiratory (eg. breathing)	Y N	
Skin (eg. cancer)	Y N	
Bones/Joints	Y N	
Blood (eg. anemia)	Y N	
Endocrine (eg. diabetes, thyroid)	Y N	
Neurological (eg. headaches)	Y N	
Psychiatric (eg. ADD, depression, anxiety)	Y N	
Allergies	Y N	

Pregnant or Nursing? ____________

Do you use tobacco? ____________

Eye surgery? ____________

For what? ________________________

Date of last eye exam: ____________ by Dr. ________________________

Family physician ____

Have you ever worn contact lenses? Y N Are you interested in contact lenses? Y N

Tablet/Mobile Device/Computer usage hours per day: ________ Hobbies/Sports? ________________________

Whom May We Thank For Referring You To Our Office? ________________________

Patient/Guardian signature: ________________________