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: ______________________ Occupation: ______________ SSN _______—_____—_______

Medical Insurance: ______________________ Vision Insurance: ______________________

Medications: ______________________

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Allergies to medications? __________ Please list: ______________________

History (circle)	Self	Family
Glaucoma		
Lazy Eye		
Macular Degeneration		
Retinal Disease		
Hyper Cholesterol		
Hypertension		
Diabetes		

System	Yes/No	Explain
Ear, Nose, Throat	Y N	
Cardiovascular (eg. heart)	Y N	
Gastrointestinal	Y N	
Genitourinary	Y N	
Respiratory (eg. breathing)	Y N	
Skin	Y N	
Bones/Joints	Y N	
Blood	Y N	
Endocrine (eg. diabetes)	Y N	
Neurological (eg. headaches)	Y N	
Psychiatric (eg. ADD)	Y N	
Allergic	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? __________ Are you interested in contact lenses? __________

Computer usage per day: __________ Hobbies? ______________ Sports? ______________

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

Patient signature: ______________________