PATIENT INFORMATION:

❑Dr. ❑Mr. ❑Mrs. ❑Ms. ❑Miss ❑Male ❑Female ❑Single ❑Married ❑Widowed ❑Partner

Name (Last, First, MI)			Nickname	
Address		City	State	Zip Code
Primary Phone	Secondary Phone	Email		
Date of Birth	Age	Social Security Number	Race	
Occupation/Title	Employer		Employer Phone Number	
Employer Address		City	State	Zip Code
Spouse or Parent's Names		Spouse or Parent's SS#	Spouse or Parent's DoB	
Who referred you?				

INSURANCE INFORMATION *(Please provide a copy of all insurance cards.)*

Name of Primary Insurance		Policy #	Group #	
Policy Holder's Names	DOB	Policy Holder's SS#	Relationship to Patient	
Employer	Employer Address	City	State	Zip

Secondary Insurance

Name of Secondary Insurance		Policy #	Group #	
Policy Holder's Names	DOB	Policy Holder's SS#	Relationship to Patient	
Employer	Employer Address	City	State	Zip

Vision Insurance

Name of Secondary Insurance		Policy #	Group #	
Policy Holder's Names	DOB	Policy Holder's SS#	Relationship to Patient	
Employer	Employer Address	City	State	Zip

Please complete other side of form.

PATIENT INFORMATION (CONTINUED)

Primary Care Physician | Phone Number

Current Medications (Prescription and over-the-counter)

Known Allergies (Medications or other) | Pharmacy | Phone Number

Date of Last Eye Exam | Date of Last Medical Exam

Do you wear glasses? ❑Y ❑N Do you wear contact lenses? ❑Y ❑N Have you had laser vision correction? ❑Y ❑N

DETAILED MEDICAL HISTORY *Do you have or have you ever had any of the following issues? If so, please explain.*

EYES
❑Y ❑N Glaucoma
❑Y ❑N Cataracts
❑Y ❑N Macular Disease
❑Y ❑N Retinal Disease
❑Y ❑N Color Vision Defect
❑Y ❑N Loss of Vision
❑Y ❑N Blurred Vision
❑Y ❑N Double Vision
❑Y ❑N Blindness
❑Y ❑N Flashes / Floaters
❑Y ❑N Halos / Glare
❑Y ❑N Dry / Gritty Discomfort
❑Y ❑N Redness / Discharge
❑Y ❑N Itching / Burning
❑Y ❑N Excessive Tearing
❑Y ❑N Lid Infection Disorder
❑Y ❑N Eye Strain
❑Y ❑N Amblyopia / Lazy Eye
❑Y ❑N Strabismus
❑Y ❑N Eye Injury
❑Y ❑N Other

CONSTITUTIONAL
❑Y ❑N Developmental Disabilities
❑Y ❑N Cancer
❑Y ❑N Fatigue Syndrome

ENT
❑Y ❑N Hearing Loss
❑Y ❑N Sinus Issues
❑Y ❑N Dry Mouth
❑Y ❑N Laryngitis

NEUROLOGICAL
❑Y ❑N Multiple Sclerosis
❑Y ❑N Epilepsy
❑Y ❑N Cerebral Palsy
❑Y ❑N Tumor
❑Y ❑N Stroke/CVA
❑Y ❑N Migraine
❑Y ❑N Autism Spectrum Disorder

PSYCHIATRIC
❑Y ❑N Depression
❑Y ❑N Attention Deficit
❑Y ❑N Anxiety Disorder
❑Y ❑N Bipolar Disorder

CARDIOVASCULAR
❑Y ❑N Hypertension
❑Y ❑N Heart Disease
❑Y ❑N Vascular Disease
❑Y ❑N Congestive Heart Failure

RESPIRATORY
❑Y ❑N Cigarette Smoker
❑Y ❑N Asthma
❑Y ❑N Bronchitis
❑Y ❑N Emphysema
❑Y ❑N COPD
❑Y ❑N Sleep Apnea

GASTROINTESTINAL
❑Y ❑N Chron's
❑Y ❑N Colitis
❑Y ❑N Ulcer
❑Y ❑N Acid Reflux
❑Y ❑N Celiac Disease

GENITOURINARY
❑Y ❑N Kidney Disease
❑Y ❑N Prostate Disease/Cancer
❑Y ❑N STD
❑Y ❑N Pregnant
❑Y ❑N Nursing
❑Y ❑N Herpes
❑Y ❑N Chlamydia

MUSCULOSKELETAL
❑Y ❑N Osteoarthritis
❑Y ❑N Arthritis
❑Y ❑N Fibromyalgia
❑Y ❑N Muscular Dystrophy
❑Y ❑N Osteoporosis
❑Y ❑N Gout

INTEGUMENTARY
❑Y ❑N Eczema
❑Y ❑N Rosacea
❑Y ❑N Psoriasis

ENDOCRINE
❑Y ❑N Type 2 Diabetes
❑Y ❑N Type 1 Diabetes
❑Y ❑N Thyroid Dysfunction
❑Y ❑N Hormonal Dysfunction

HEMATOLOGIC/LYMPHATIC
❑Y ❑N Anemia
❑Y ❑N Ulcer

ALLERGIC/IMMUNE
❑Y ❑N Drug Allergies
❑Y ❑N Environmental Allergies
❑Y ❑N Rheumatoid Arthritis
❑Y ❑N HIV/AIDS

OTHER: _____

_____

FAMILY MEDICAL HISTORY *(Please list any known family history of diseases - diabetes, stroke, glaucoma, etc.)*

Mother | Father

Siblings

PATIENT SOCIAL HISTORY *(Please complete the social history information - Your answers are confidential)*

Use of Alcohol ❑ Never ❑Previously, but Quit ❑ Rarely ❑ Regularly How Much? _____

Use of Tobacc ❑ Never ❑Previously, but Quit ❑ Rarely ❑ Regularly How Much? _____

Please complete other side of form.