Patient Information (*Please Print*)

First:	Last:	Date:
Address:	DOB:	Age:

City:	State:	Zip Code:	Sex: *(Circle One)* Female Male	Title: *(Circle One)* Mr. Mrs. Ms. Miss Dr.

Home Phone: Mobile Phone:

Email address:

How did you hear about our office:
☐ Previous patient ☐ Insurance ☐ Advertisement ☐ Other:_____

Occupation:

Reason For Visit today?
(*Please check all that apply*)

☐ Annual Exam ☐ Eye Strain ☐ Tearing/watery eyes
☐ Contact lenses ☐ Frequent headaches
☐ Glasses ☐ Double vision ☐ Floaters/ Flashes
☐ Burning, stinging eyes ☐ Red eye/Eye Infection
☐ Dry eyes ☐ Stye ☐ Light sensitivity

Blurry Vision
☐ Far ☐ Near ☐ With glasses

Eye Health: Do you have or have ever had?
(*Please check all that apply*)

☐ Eye Injury ☐ Strabismus
☐ Eye Surgery/Lasik ☐ Vision Therapy
☐ Cataracts ☐ Glaucoma
☐ Pterygium ☐ Corneal Disease
☐ Retinal Disorder ☐ Stroke
☐ Blindness ☐ Macular Degeneration
☐ Chalazion ☐ Other:_____

Have your eyes been dilated: ☐ yes ☐ no when:_____

Personal/Family Health History:
(*Please Check all that apply*)

	Self	**Blood Relative**
Diabetes	_____	_____
Heart Disease	_____	_____
High Blood Pressure	_____	_____
Thyroid Disease	_____	_____
High Cholesterol	_____	_____
Rheumatoid Arthritis	_____	_____
Stroke	_____	_____
Cancer	_____	_____
Lupus	_____	_____
AIDS/HIV	_____	_____

☐ Allergies/hay fever
☐ Pregnant(*females only*)
☐ Other:_____
☐ Hospitalizations/Surgeries
_____Date/Year:_____

_____Date/Year:_____

Do you wear?
☐ Glasses ☐ Contact

If yes: Kind_____
How often are you on the computer? Per day?
_____

Date of last eye exam:_____

Age of current glasses:_____

Medication Allergies:
(*Please list all medication allergies you have*)
_____ _____

_____ _____

Medications: Are you currently taking?
(*Please list all medications being taken and dosage)*

_____dosage_____

_____dosage_____

_____ _____

Signature of Patient/Guardian **Date**