(Please print the answers to ALL questions. Your information will remain confidential per HIPAA policy)

Name: _____ DOB: _____ Last 4 SS: _____ Sex: ❑Male ❑Female
First Last optional

Street Address: _____Apt _____City _____State_____ Zip_____

Cell Phone: _____ Home Phone: _____ Email: _____

Occupation (or Grade):_____ Employer (or School):_____

Race: ❑White ❑ Black/ African American ❑ Asian ❑Hispanic ❑ Native American ❑ Other

If minor, PARENT/GUARDIAN name: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Your Medical Doctor: _____ Phone: _____

When was your last eye exam? (Approx:) _____Doctors Name/ Location: _____

Reason for visit today: Circle one: Annual Eye exam / Contacts / Both or
Office Visit**:** Reason for office visit: _____

If you have an Eye Infection, Injury or an Irritation, please answer these questions:
Which eye? ❑ Both ❑ Right eye ❑ Left eye For how long? _____
What have you done to treat your eye? _____ Name any drops you used: _____
Did something get into your eye? _____If yes, what were you doing? _____

Do you have any of the following problems?

❑Eye Pain or Soreness	❑Chronic Infection of Eye or Lid	❑ Loss of Vision	❑ Blurred Vision	❑ Redness
❑ Distorted Vision/Halos	❑ Loss of Side Vision	❑ Double Vision	❑ Dryness	❑ Mucous Discharge
❑ Sandy/Gritty Feeling	❑ Itching	❑Floaters/Flashes	❑Burning	❑Excess Tearing/Watering
❑Glare/Light Sensitivity	❑ Tired Eyes	❑ Styes or Chalazion		❑ Foreign Body Sensation

❑ Other _____

Eye Health:

Eye surgeries : ❑ None ❑ Lasik ❑ RK ❑ Cataract ❑ Retina ❑ Glaucoma ❑ Eyelid ❑ Other_____

What is your Computer/phone use per day:❑ Extensive (5+ hrs) ❑ Moderate (1-4 hrs) ❑ Low (1hr or less) ❑ Seldom/Never
Do you wear GLASSES? _____ If YES, do you have them with you TODAY? _____
Do you wear contacts? Yes / No What brand are the contacts? _____
What is the prescription: Right Eye: _____ Left Eye: _____

PLEASE FILL OUT THE BACK SIDE 

Personal Medical History / Social History:

Do you have any medication allergies: ❑ None known ❑ Penicillin ❑ Sulfa drugs ❑ Other: _____
Use Tobacco: Yes / No **Alcohol Beverages:** Yes / No **Pregnant:** Yes / No **Breast Feeding:** Yes / No

Review of Systems: Please circle all that apply:

Constitutional:	fever	weight loss	trauma	cancer	fatigue
Allergic/ Immunologic:	Drug Allergies	Rheumatoid	Environmental	Lupus	
Cardiovascular:	High BP	Stroke	Heart Disease	Cholesterol	
Genital, Kidney, Bladder:	Kidney Concerns UTI	STD/HIV			
Ear, Nose, Throat:	Upper Respiratory Tract Infection		Sinus		
Neurological:	Headaches	Migraines	Seizures MS	Epilepsy	
Endorcrine:	Diabetes	Thyroid	Hormonal Dysfunction		
Blood/Lymph:	Anemia	Lukemia,	Bleeding Disorders		
Psychiatric:	Depression	Anxiety	Insomnia		
Gastrointestinal:	Colitis	Chron's	Ulcer	Reflux	
Muscles, Bones, Joints:	Arthritis	Fibromyalgia	Head or Neck Injury		
Skin:	Eczema	Rosacea	Psoriasis	Skin Cancer	
Respiratory:	Asthma	Bronchitis,	Emphysema	COPD	

Diabetic Information:

What type of Diabetes do you have? Type 1 / Type 2 HbA1C (Lab test Result) : _____ date of last test: _____
Last Glucose reading (Check at home)? _____ Date of reading? _____ Diabetes under Control?: Yes / No

Please list ALL medications:

_____

_____

_____

_____

Family Medical History:

Is there any family medical history of any of the following? ❑ None
(If yes, please list their relationship to you)

❑ Corneal Disease _____ ❑ Blindness _____ ❑ Lazy Eye _____
❑ Cataracts _____ ❑ Diabetes _____ ❑ Glaucoma _____
❑ Heart Disease _____ ❑ Macular_____ ❑ Hereditary Disease_____
❑ Retinal _____ ❑ Other Eye Disorders_____