Today's Date: _____

Name: _____ Birthdate: _____ Age: _____ ☐ M ☐ F
Address:_____City: _____ State: ____ Zip: _____
Cell Phone: _____Home Phone: _____**Email:**_____
Employer: _____ Occupation: _____
SS: _____ Primary Care Physician: _____ Physician Phone:_____
Spouse / Parent / Emergency Contact: _____Phone: _____
Preferred Pharmacy:_____ Pharmacy Phone: _____

For patients 18 years of age and older: List the names of people with whom we may discuss your financial and health information:
_____

Remind me of my appointments by (mark all that apply): ☐ **Phone** ☐ **Text** ☐ **Email**

Whom May We Thank for Referring You?_____

INSURANCE
Medical Insurance Plan: _____ ID#: _____Group#:_____
Vision Insurance Plan: _____ ID#: _____Group#:_____
Primary Insured Name: _____ Primary Insured Birthdate: _____

CONTACTS

Do you wear contacts? ☐ Yes ☐ No What Brand? _____ What solution do you use? _____
Power of your contacts: Right:_____ Left:_____ What do you dislike about your contacts?_____
How often do you replace your contacts? _____ How often do you sleep in your contacts? _____

MEDICAL HISTORY
Date Last Eye Exam: _____ By Whom: _____ Date Last Medical Exam: _____ By Whom: _____
Medications:_____
Any Allergies:_____

Do you wear glasses? ☐ Yes ☐ No How old are your glasses? _____

Do you Smoke? ☐ Yes ☐ No Do you drink Alcohol? ☐ Yes ☐ No ☐ Only Socially

Are you Pregnant? ☐ Yes ☐ No Are you Nursing? ☐ Yes ☐ No

What is the reason for your visit today?_____

Please check the box for the conditions for which you have been diagnosed or treated and list family members with any conditions.

GENERAL HEALTH	You	Family	EYE HEALTH	You	Family
High Blood Pressure	☐		Cataracts	☐	
High Cholesterol	☐		Cataract Implants	☐	
Diabetes (Insulin, pills, diet-controlled)	☐		Eye Surgery ☐ R ☐ L	☐	
Thyroid Disease	☐		Lazy Eye (Amblyopia)	☐	
Heart Disease (Stroke, heart attack, other)	☐		Eye Injury ☐ R ☐ L	☐	
Respiratory Disease	☐		Glaucoma	☐	
Asthma	☐		Macular Degeneration	☐	
Autoimmune disease	☐		Other Retinal Disease	☐	
HIV or AIDS	☐		Vision Loss or Blindness	☐	
Herpes Virus (Oral/Genital)	☐		Keratoconus	☐	
Liver or Kidney disease	☐		Other Corneal Disease	☐	
Cancer	☐		Dry Eyes Drops Used:	☐	
Sinus Condition	☐		Floaters or Flashing Lights	☐	
Environmental Allergies	☐		Eye Itching	☐	
Arthritis (RA or OA)	☐		Eye Redness	☐	
Migraines or Headaches	☐		Eye Pain	☐	
Other:	☐		Other:	☐	
NO Health Conditions	☐		**NO Eye Conditions**	☐	