



PATIENT HISTORY

REFERRING DOCTOR: _____

CONTACT INFORMATION

First Name:		Last Name:		DOB:	Gender: M F
Address:		City:		State:	Zip:
Phone:	E-mail:		Occupation:		
Emergency Contact:			Emergency Phone:		
Preferred Pharmacy:					

MEDICAL HISTORY

Do you have allergies? If yes, explain:

List all medications you take (including over the counter) or provide us a list:

Are you currently being treated for any medical condition? If yes, please explain:

FAMILY HISTORY

Is there a family history of eye disease? If yes, explain:

Do you smoke? If yes, how much:			Do you drink? If yes, how much:		
Have you ever had or been told that you have?	Yes	No		Yes	No
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):					

EYE HISTORY

When was your last exam?	Doctors Name/City:				
How old are your current glasses?	Do you wear contacts? Yes		How old are your contacts?		
How often do you use glasses?	Never	Constantly	Reading Only	Distance Only	Rarely

SIGNATURE: _____

DATE: _____