PATIENT INFORMATION

Last Name:_____ First Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ State:_____ Zip:_____

Last 4 of SSN:_____ Email Address: _____

Home #:_____ Work #:_____ Mobile #:_____

Occupation:_____ Employer:_____

Spouse Name:_____ Parent / Guardian Name:_____

Do you wear: ☐ Glasses ☐ Contact Lenses

Do you have **VISION** INSURANCE? YES / NO Vision Insurance Co.:_____

Policy Holder's Name:_____ DOB:_____ Last 4 of SSN:_____

Do you have **MEDICAL** INSURANCE? YES / NO Medical Insurance Co.:_____

Policy Holder's Name:_____ DOB:_____ Last 4 of SSN:_____

OPTIONAL ***(Circle One)***

Preferred Language: English | Spanish | French | Japanese | Decline to Specify

Race: American Indian or Alaska Native | Asian | Black or African American | Hispanic | Native Hawaiian or Other Pacific Islander | White or Caucasian Decline to Specify

HEALTH HISTORY

Current Medication(s):_____

_____

Primary Care Physician or Family Doctor: _____

Are you allergic to any medication(s)? Yes / No If yes, complete the following:

Drug allergies:_____ Reaction:_____

**Female only: I am, or think I may be, pregnant: Yes / No If yes, are you nursing? Yes / No

*****Are you, or have you ever experienced any problems in the following areas?***

	No	Yes
System Constitutional		
Fever/Weight Loss/Gain	N	Y
Integumentary		
Eczema	N	Y
Psoriasis	N	Y
Cancer	N	Y
Neurological		
Headaches	N	Y
Migraines	N	Y
Seizures	N	Y
Multiple Sclerosis	N	Y
Cancer	N	Y
Ear/Nose/Throat		
Allergies/Hay Fever	N	Y
Sinus Congestion	N	Y
Chronic Cough	N	Y
Dry Throat/Mouth	N	Y

	No	Yes
Endocrine		
Non-Insulin Dependent Diabetes	N	Y
Insulin Dependent Diabetes	N	Y
Thyrod Dysfunction	N	Y
Hormonal Dysfunction	N	Y
Respiratory		
Asthma	N	Y
Chronic Bronchitis	N	Y
Emphysema	N	Y
Cancer	N	Y
Vascular/Cardiovascular		
High Blood Pressure	N	Y
High Cholesterol	N	Y
Stroke	N	Y
Heart Disease	N	Y
Lymphatic/Hematological		
Bleeding Problems	N	Y

	No	Yes
Gastrointestinal		
Crohn's	N	Y
Colitis	N	Y
Ulcer	N	Y
Digestive	N	Y
Genitourinary		
Genitals/Kidney/Bladder	N	Y
Allery/Immunological		
Drug Allergy	N	Y
Environmental Allergy	N	Y
Rheumatoid Arthritis	N	Y
Lupus	N	Y
Psychiatric		
Depression	N	Y
Panic Disorder	N	Y
Schizophrenia	N	Y

*****YOUR EYE SYMPTOMS*** - Do you (patient) experience any of the following?

Blurred Vision	N	Y
Distorted Vision	N	Y
Double Vision	N	Y
Red Eyes	N	Y
Watery Eyes	N	Y
Itchy Eyes	N	Y
Burning Eyes	N	Y
Dry Eyes	N	Y

Color Vision Difficulties	N	Y
Depth Perception Problem	N	Y
Losing Place While Reading	N	Y
Night Vision Problems	N	Y
Extremem Light Sensitivity	N	Y
Discharge From Eyes	N	Y
Floating Spots	N	Y
Seeing Rings Around Lights	N	Y

Flashing Lights	N	Y
Painful Eyes	N	Y
Gritty/Sandy Eyes	N	Y
Aching Eyes	N	Y
Drawing/Pulling	N	Y
Dizziness	N	Y
Excessive Squinting	N	Y
Other:_____		

*****FAMILY HISTORY*** - Has anyone in the patient's family (blood relative) had any of the following?

Cataracts	N	Y
Cornea Disease	N	Y
Crossed Eyes	N	Y
Retina Disease	N	Y

Glaucoma	N	Y
Lazy Eye	N	Y
Macular Degeneration	N	Y
Cancer	N	Y

Heart Disease	N	Y
Diabetes	N	Y
High Blood Pressure	N	Y
Other:_____		

*****SOCIAL HISTORY*** - *This information is kept strictly confidential. However, you may discuss this portion directly with your doctor if you prefer.*

Do you use tobacco? N Y If yes, type/amount/how long?_____

Do you drink alcohol? N Y If yes, type/amount/how long?_____

Height_____ Weight_____