Name ___________________________________ Date of Birth _______________________
Spouse/Parent ____________________________ Age ___
Address ________________________________ Male ___ Female___ Eye Color ____
_______________________________________ Phone Number _______-______-______
Occupation ______________________________ Work Number _______-______-______
Social Security Number _______-______-______

Vision Insurance ____
Medical Insurance ____
Medical Physician ____

Past Ocular History

Date of Last Eye Exam ______________ Date of Last Pair of Glasses________________________
History of eye trauma ____
History of eye surgery ____
Eye diseases (glaucoma, cataracts, retinal detachment, macular degeneration) _______________
____
*Are you interested in Laser Vision Correction? Yes _____ No _____

Past and Present Medical History

Medication Allergies _______________________ Environmental Allergies ____________________
Current Medications ____
Previous Surgeries ____
Eye Medications ____

Medical Conditions

	Yes	No		Yes	No
Thyroid Disease			Respiratory		
Blindness			Fever/Weight Loss		
Heart Disease			Muscle/Bone/Joint		
Diabetes			Blood/Bleeding Disorder		
High Blood Pressure			Abdominal Problems		
Nervous System Disorder			Genital/Urinary		
Psychological Disorder			Ear/Nose/Mouth/Throat		
Social History Smoking					
Alchohol					
Drugs					
Family History	**Yes**	**No**		**Yes**	**No**
Glaucoma			Heart Disease		
Cataracts			Hypertension		
Crosses/Lazy Eyes			Diabetes		
Retinal Detachment			Blindness		

Referred by: ____

Date/Initial ___________ Date/Initial ___________ Date/Initial ___________ Date/Initial ___________