

Name \_\_\_\_\_  
 Spouse/Parent \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth \_\_\_\_\_  
 Age \_\_\_\_\_  
 Male \_\_\_ Female \_\_\_ Eye Color \_\_\_\_\_  
 Phone Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 Work Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
 E-Mail \_\_\_\_\_

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		
<b>Social History</b>					
Smoking					
Alcohol					
Drugs					
<b>Family History</b>	Yes	No		Yes	No
Glaucoma			Heart Disease		
Cataracts			Hypertension		