Medical History

Allergies		Ocular History	
Medications		Injuries/ Surgeries	

Family Medical History: Note relation to yourself in the box (example: "Mother", "Paternal Grandfather" etc.)

☐ Blindness		☐ Cancer	
☐ Cataracts		☐ Diabetes	
☐ Macular Degeneration		☐ Heart Disease	
☐ Glaucoma		☐ High Blood Pressure	
☐ Retinal Detatchment		☐ Kidney Disease	
☐ Crossed Eyes		☐ Arthritis	
☐ Lupus		☐ Thyroid Disease	

Other: ______ ☐ Currently pregnant or nursing.

☐ Doesn't Drive ☐ Drives ☐ Doesn't Use Tobacco ☐ Uses Tobacco

Driving Difficulties ______ Type/Amount/How Long? ______

☐ Doesn't Drink Alcohol ☐ Drinks Alcohol ☐ Doesn't Use Illegal Drugs ☐ Uses Illegal Drugs

Type/Amt/HowLong ______ Type/Amt/HowLong ______

Have you ever been exposed to or infected with ☐ Gonhorrhea ☐ Hepatitis ☐ Syphilis ☐ HIV

Review of Systems. Please check all that apply to you.

Eyes	☐ Flashes	☐ Weight Loss/Gain	☐ Hormonal Dysfunction	**Allergic/Immune**	**Musculoskeletal**
☐ Vision Loss	☐ Floating Spots	☐ Fatigue	**Respiratory**	☐ Drug Allergies	☐ Fibromyalgia
☐ Blurry Vision	☐ Tired Eyes	☐ Trauma	☐ Asthma	☐ Seasonal Allergies	☐ Muscular Dystrophy
☐ Distorted Vision	☐ Cataracts	**Integumentary (Skin)**	☐ Bronchitis	☐ Lupus	☐ Osteoarthritis
☐ Double Vision	☐ Diabetic Retinopathy	☐ Eczema	☐ Emphysema	☐ Arthritis	☐ Ankylosing Spond.
☐ Dryness	☐ Glaucoma	☐ Rosacea	**Cardiovascular**	**Lymphatic/Hematologic**	**Genitourinary**
☐ Redness	☐ Macular Degeneration	☐ Psoriasis	☐ Heart Disease	☐ Anemia	☐ Kidney Problems
☐ Mucous Discharge	☐ Retinal Detatchment	**Neurologic**	☐ Hypertension	☐ Bleeding Problems	☐ Bladder Problems
☐ Gritty Feeling	**Gastrointestinal**	☐ Headaches	☐ Hypercholesterolemia	☐ Leukemia	☐ STD's
☐ Itching	☐ Colitis	☐ Migraines	**Ears/Nose/Throat**		
☐ Burning	☐ Crohn's Disease	☐ Seizures	☐ Allergies		
☐ Excess Watering	☐ Ulcers	☐ Mult. Sclerosis	☐ Sinus Congestion	Please list any other symptoms you may be experiencing.	
☐ Light Sensitivity	☐ Constipation	**Endochrine**	☐ Runny Nose		
☐ Eye Pain/Soreness	☐ Diarrhea	☐ Non Insulin Diabetes	☐ Post Nasal Drip		
☐ Chronic Infection	**Constitutional**	☐ Insulin Diabetes	☐ Chronic Cough		
☐ Sties	☐ Fever	☐ Thyroid Dysfunction	☐ Dry Throat/Mouth		

Welcome to our office!

Please fill out this form as completely as possible and return it to the desk.

Name of Doctor you wish to see: ______ Today's Date ______

Name ______ Email Address ______

Address ______ Home Phone ______

Apt.# ______ ☐ Male ☐ Female Cell Phone ______

City ______ State ______ Zip Code ______ Work Phone ______

Date of Birth ______ SSN ______ Fax Phone ______

Primary Care Physician ______ Phone ______

Previous Eye Doctor ______ Phone ______

Last Eye Exam ______ Referred By ______

Vision Insurance Information

Insurance ______ Card Number or I.D.# ______

Cardholder ______ Group Number ______

Address ______ Apt.# ______

City ______ State ______ Zip Code ______ Date of Birth ______

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Medical Insurance Information

Insurance ______ Card Number or I.D.# ______

Cardholder ______ Group Number ______

Address: ______ Apt.# ______

City ______ State ______ Zip Code ______ Date of Birth ______

Relationship to Insured: ☐ Child ☐ Spouse ☐ Other

Employer ______ Sports/Hobbies ______

Occupation ______ Emergency Contact ______ Phone ______

☐ I wear Glasses ☐ I wear contact lenses ☐ Soft ☐ Hard What brand of contact lens do you currently wear? ______

Are the contact lenses you are currently wearing comfortable? ☐ Yes ☐ No