

Patient's Name: _____ Marital Status: _____ Date of Birth: ___ / ___ / ___
 State of Birth: _____ Mother's Maiden Name: _____ Parent's Name: _____
 Best way to contact you: Home Ph. Cell Ph. Work Ph. eMail Hm. Phone: _____
 Cell Phone: _____ Work Phone: _____ eMail: _____
 Subscriber Name: _____ Address: _____
 Date of Birth: ___ / ___ / ___ Sex: ___ Relation to Patient: _____
 Emergency Contact: _____ Phone # _____ Relationship: _____
 Medical Insurance Name: _____ ID/Plan# _____
 Family Physician: _____ Phone # _____
 What special vision need do you have? _____

Medical History

Do your vision problems occur at: Distance ___ Near ___ Computer ___
 Do you have headaches? Yes ___ No ___ How often: _____
 Are your eyes sensitive to sunlight? Yes ___ No ___
 Do your eyes: Burn ___ Ache ___ Tire ___ Itch ___ Water ___ Get Red ___ Dry Out ___
 Do you work with a computer? Yes ___ No ___ If yes, how many hours per day? ___ Working Dist. _____
 List all medications you are currently taking: (include birth control, hormones, over the counter medications) _____
 List all medications that you are allergic to: _____
 Are you pregnant or nursing? Yes ___ No ___
 Have you ever had any injuries to your eyes? Yes ___ No ___ Explain _____
 Have you had any surgeries? Yes ___ No ___ Explain _____
 Eye surgery ___ Glaucoma ___ Retinal Detachment ___ Crossed Eyes ___ Cataracts ___ Lasik ___ RK ___ CK ___
 Do you wear glasses? Yes ___ No ___
 Do you wear contact lenses? Yes ___ No ___ If yes, how many pair do you have left? _____
 What contact lens solutions do you use _____
 Have you ever worn your lenses over-night? Yes ___ No ___

Social History

Hobbies: _____ Occupation: _____
 Do you drive? Yes ___ No ___ Any difficulty seeing while you drive? _____
 Have you ever used tobacco products? Yes ___ No ___ For how long? _____
 Do you drink alcohol? Yes ___ No ___ How much/how long? _____
 Do you use illegal drugs? Yes ___ No ___ What type/how long? _____
 Have you ever been exposed or infected with: Gonorrhea ___ Syphilis ___ HIV ___ Hepatitis ___ None

Family History

Has any family member ever had any of the following: (Please indicate with an X)

	You	Parents	Grandparent	Siblings	Other
Asthma					
Blindness					
Cataracts					
Diabetes					
Glaucoma					
Macular Degeneration					
Retinal Detachment					
Crossed Eyes					
Arthritis					
Cancer					
Heart Disease					
High Blood Pressure					
Kidney Disease					
Lupus					
Thyroid Disease					
Other (Explain)					