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 __ Height_____ Weight_____
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)					

Do you currently, or have you ever had *any* problems in the following areas: (If YES, please explain and list medications)

System	Yes	No	Explain	Medication
EYES				
Loss of Vision				
Blurred Vision				
Distorted Vision *I* Haloes				
Loss of Side Vision				
Double Vision				
Dryness				
Mucous Discharge				
Redness				
Sandy or Gritty Feeling				
Itching				
Burning				
Foreign Body Sensation				
Excess Tearing *I* Watering				
Glare *I* Light Sensitivity				
Eye Pain or Soreness				
Chronic Infection of Eye or Lid				
Sties or Chalazion				
Flashes *I* Floaters in Vision				
Tired Eyes				
EARS,NOSE,MOUTH,THROAT				
Allergies				
Hay Fever				
Sinus Congestion				
Runny Nose				
Post-Nasal Drip				
Chronic Cough				
Dry Throat *I* Mouth				
RESPIRATORY				
Asthma				
Chronic Bronchitis				
Emphysema				
VASCULAR				
Heart Pain				
High Blood Pressure				
Vascular Disease				
GASTROINTESTINAL				
Diarrhea				
Constipation				
GENITOURINARY (genitals *I* kidney *I* bladder)				
BONES *I* JOINTS *I* MUSCLES				
Rheumatoid Arthritis				
Muscle Pain				
Joint Pain				
LYMPHATIC *I* HEMATOLOGIC				
Anemia				
Bleeding Problems				
ENDOCRINE				
Diabetes				
Thyroid				
PSYCHIATRIC				