Today's Date: _____ Name: _____ Date of Birth: _____

Address: _____

SSN#: _____ Ethnicity: Hispanic/Non-Hispanic Preferred Language: _____ Race: _____

May we contact you by Email: Yes No Email Address: _____@_____

May we contact you by cell phone? Yes No Cell #: _____

Phone we may contact you directly other than personal cell: _____

Whose phone number is this? _____ Is it a cell / work / home ?

Employer: _____ Occupational : _____

How do you use your eyes at work? _____

Do you have any hobbies that require special glasses or contacts? _____

If you are 12 years of age or older, do you currently use: _____ Cigarettes _____ Alcohol _____Abuse Drugs

Are you pregnant or nursing? Yes No If pregnant, how many months? _____

If you are 18 years of age or younger did you meet all developmental milestones (talking, walking, school) on time? _____

If not, explain _____

Previous Eye Surgery: Yes No _____

CURRENT MEDICATIONS

1. _____for_____
2. _____for_____
3. _____for_____
4. _____for_____
5. _____for_____
6. _____for_____
7. _____for_____
8. _____for_____
9. _____for_____
10. _____for_____

DRUG ALLERGIES: Yes No Please list: _____

Family Physician:
Name: _____ Address: _____ Phone: _____

Who may we thank for referring you to our office?

Family/Friend? Name: _____

Another doctor? Name: _____ Web site? _____ Insurance Co: _____

PLEASE FILL OUT THE BACK OF THIS SHEET.

Current Eye Symptoms/ Conditions								
Headaches	Yes	No	Excess Tearing/Watering	Yes	No	Blurred Distance Vision	Yes	No
Glare/Light Sensitivity	Yes	No	Eye Pain/ Soreness	Yes	No	Blurred Near Vision	Yes	No
Tired Eyes	Yes	No	Sandy/Gritty Feeling	Yes	No	Fluctuating Vision	Yes	No
Amblyopia/Lazy Eye	Yes	No	Foreign Body Sensation	Yes	No	Glaucoma	Yes	No
Burning	Yes	No	Mucous Discharge	Yes	No	Cataracts	Yes	No
Dryness	Yes	No	Distorted Vision/Halos	Yes	No	Retinal Detachment	Yes	No
Itching	Yes	No	Loss of Side Vision	Yes	No	Macular Degeneration	Yes	No
Redness	Yes	No	Floaters/Spots	Yes	No	Previous Eye Surgery	Yes	No
			Indicate any personal medical history below:					
Constitution						***Gastrointestional***		
Developmental Disabilities	Yes	No	Osteoarthritis	Yes	No	Crohns	Yes	No
Fatigue Syndrome	Yes	No	Ankylosing Spondylitis	Yes	No	Colitis	Yes	No
Cancer	Yes	No	Gout	Yes	No	Celiac Disease	Yes	No
Other_____	Yes	No	Osteoporosis	Yes	No	Ulcers	Yes	No
Ear/Nose/Throat						Acid Reflux	Yes	No
Hearing Loss	Yes	No	***Cardiovascular***			Other _____	Yes	No
Sinusitis	Yes	No	Vascular Disease	Yes	No	***Integumentary***		
Dry Mouth	Yes	No	Congestive Heart Failure	Yes	No	Eczema	Yes	No
Laryngitis	Yes	No	Heart Disease	Yes	No	Herpes Zoster/Shingles	Yes	No
Neurological			High Blood Pressure	Yes	No	Psoriasis	Yes	No
Migraine	Yes	No	Stroke/CVA	Yes	No	Herpes Simples/Cold Sores	Yes	No
Stroke/CVA	Yes	No	***Respiratory***			Rosacea	Yes	No
Tumor	Yes	No	Asthma	Yes	No	Other _____	Yes	No
Cerebral Palsy	Yes	No	Cigarette Smoker	Yes	No	***Endocrine***		
Epilepsy	Yes	No	Emphysema	Yes	No	Type 2 Diabetic	Yes	No
Multiple Sclerosis	Yes	No	Bronchitis	Yes	No	Hormonal Dysfunction	Yes	No
Other_____	Yes	No	Sleep Apnea	Yes	No	Thyroid Dysfunction	Yes	No
Psychological			Chronic Obstruction	Yes	No	Type 1 Diabetes	Yes	No
Bipolar Disorder	Yes	No	***Genitourinary***			Other _____	Yes	No
Anxiety Disorder	Yes	No	STD	Yes	No	***Hemotologic/Lymphatic***		
Attention Deficit	Yes	No	Chlamydia	Yes	No	Large Volume Blood Loss	Yes	No
Depression	Yes	No	Herpes	Yes	No	Anemia	Yes	No
Other _____	Yes	No	Benign Prostate	Yes	No	High Cholesterol	Yes	No
Musculoskeletal			Prostate Disease/ Cancer	Yes	No	Ulcer	Yes	No
Arthritis	Yes	No	Kidney Disease/Hypertrophy	Yes	No	Other _____	Yes	No
Fibromyalgia	Yes	No	Pregnant	Yes	No			
Muscular Dystrophy	Yes	No	Nursing	Yes	No			

Family Medical History					Other						Other					
High Blood Pressure	*Mom*	*Dad*	*Bro*	*Sis*		Cancer	*Mom*	*Dad*	*Bro*	*Sis*		HypoThyroid	Mom	Dad	Bro	Sis
Diabetes Type 1	*Mom*	*Dad*	*Bro*	*Sis*		HyperThyroid	*Mom*	*Dad*	*Bro*	*Sis*						
Diabetes Type 2	*Mom*	*Dad*	*Bro*	*Sis*												
Family Ocular History					Other						Other					
Cataracts	*Mom*	*Dad*	*Bro*	*Sis*		Retinal Detachment	*Mom*	*Dad*	*Bro*	*Sis*						
Glaucoma	*Mom*	*Dad*	*Bro*	*Sis*		Other	*Mom*	*Dad*	*Bro*	*Sis*						
Macular Degeneration	*Mom*	*Dad*	*Bro*	*Sis*												