Welcome to our practice!

Name_____
Address_____City_____State_____Zip_____
Date of Birth_____ Social Security #_____ Gender M F
Phone Numbers (home)_____(work)_____(cell)_____
Email_____ Which way would you prefer we contact you?_____
Occupation_____Employer_____
Parent/Guardian_____
Might we have you listed under a previous name?_____
Whom may we thank for recommending you to our office?_____
Will you be using insurance to help pay for your charges? Y N (please give card to receptionist)

Please indicate if you are interested in discussing:
- ☐ Glasses, computer eyewear, sunglasses, or sports glasses
- ☐ Contact lenses. Have you worn them before? Y N
- ☐ Vision corrective surgery

Approximate date of your last eye exam_____ Previous Eye Dr Name_____
Who is your family doctor_____

Please complete the following information regarding your eye/health history

Do you drink Alcohol? Y N If yes, how much?_____
Do you smoke? Y N If yes, how much?_____If no, have you ever smoked? Y N

Have you or family members ever had (please indicate who)
- ☐ Glaucoma_____
- ☐ Cataracts_____
- ☐ Macular degeneration/retinal disease_____
- ☐ Eye injury/surgery_____
- ☐ Dry eyes_____
- ☐ Other eye disease_____

Do you have a family history (please indicate who)
- ☐ Cancer_____
- ☐ Type 1 diabetes_____
- ☐ Type 2 diabetes_____
- ☐ High blood pressure_____
- ☐ Thyroid dysfunction_____

Please document your current health (please circle your diagnosis)
- ☐ Constitution: developmental disabilities, cancer, fatigue syndrome, other_____
- ☐ Ear/Nose/Throat: hearing loss, sinusitis, dry mouth, laryngitis, other_____
- ☐ Neurological: MS, epilepsy, CP, tumor, migraine, autism spectrum, other_____
- ☐ Psychiatric: depression, attention deficit, anxiety, bipolar, other_____
- ☐ Cardiovascular: high blood pressure, stroke, heart disease, vascular disease, congestive heart failure
- ☐ Respiratory: smoker, asthma, bronchitis, emphysema, chronic obstruction, sleep apnea, other_____
- ☐ Gastrointestinal: Crohn's, colitis, ulcer, acid reflux, celiac disease, other_____
- ☐ Genitourinary: kidney disease, prostate disease, STD, pregnant, nursing, other_____
- ☐ Musculoskeletal: arthritis, fibromyalgia, muscular dystrophy, osteoporosis, gout_____
- ☐ Skin: eczema, rosacea, psoriasis, herpes simplex/zoster, other_____
- ☐ Endocrine: type 1 diabetes, type 2 diabetes, thyroid dysfunction, hormone dysfunction, other_____
- ☐ Blood: anemia, high cholesterol, other_____
- ☐ Allergic/immune: environmental allergies, RA, Lupus, Sjogren's syndrome, other_____

Current medications, including eye drops (or attach list)_____
_____
_____
Drug allergies_____