

Last Name _____ First Name _____
Address _____ Apt _____ City _____ State _____ Zip _____
Telephone (H) _____ (W) _____
SSN _____ - _____ - _____ Date of Birth _____
Occupation _____ Employer _____
Emergency Contact/Telephone No. _____
Date of Last Eye Exam _____

MEDICAL INFORMATION

Do you have problems with any of these systems? *(please circle all that apply)*

Stomach/G.I.	Y/N	Nervous System	Y/N	Blood/Lymph	Y/N
Ears/Nose/Throat	Y/N	Muscle/Bone	Y/N	Mental Health	Y/N
Cardiovascular	Y/N	Skin	Y/N		
Respiratory	Y/N	Endocrine (glands)	Y/N		

Please Explain _____

PLEASE ANSWER ALL THAT APPLY:

Diabetes Y/N Type I or II? _____ Date of Diagnosis _____
High blood pressure Y/N Date of Diagnosis _____
Allergies Y/N Allergic to what? _____ What happens? _____
Medication Allergy Y/N What happens? _____
Headaches Y/N Location/Frequency _____
Current Medication(s) _____
Have you had any operations? Y/N Kind? _____ When? _____
Name of family doctor _____ Date of last visit _____

FAMILY HISTORY

High Blood Pressure Y/N Relation _____ Diabetes Y/N Relation _____
Cataracts Y/N Relation _____ Macular Degeneration Y/N Relation _____
Glaucoma Y/N Relation _____ Retinal Detachment Y/N Relation _____
Other eye condition(s) Y/N What kind? _____ Relation _____

PERSONAL EYE INFORMATION

Have you had any eye injuries? Y/N Kind _____ Date _____
Have you had any eye operations? Y/N Type _____ Date _____
Do you have Glaucoma Y/N Cataracts Y/N Dry eyes Y/N Blurred vision Y/N
Other eye problems Y/N Please describe _____
Do you wear glasses Y/N Contact Lenses Y/N Kind/Brand _____
Are you interested in Laser Vision Correction Y/N
Whom may we thank for referring you? _____

X _____ Date _____
Please sign here

X _____ Date _____
Please sign here

X _____ Date _____
Please sign here

X _____ Date _____
Please sign here