

Today's date \_\_\_\_\_

**PATIENT HISTORY**

Name Dr./Mr./Mrs./Ms/Miss \_\_\_\_\_ MI \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_  
 Telephone (H) \_\_\_\_\_ (W) \_\_\_\_\_  
 SSN \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Occupation \_\_\_\_\_ E-mail \_\_\_\_\_  
 Employer \_\_\_\_\_  
 Approximate date of last eye exam \_\_\_\_\_ Last eye doctor and location \_\_\_\_\_

**MEDICAL INFORMATION**

How is your general health? \_\_\_\_\_  
 Do you have problems with any of these systems? (*please circle all that apply*)

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/Lymph	Y/N
Respiratory	Y/N	Skin	Y/N	Allergic/immunologic	Y/N

Please explain \_\_\_\_\_

*Please answer all that apply:*

Diabetes Y/N Type \_\_\_\_\_ Date of diagnosis \_\_\_\_\_ Well Controlled Y/N  
 Medication Allergies Y/N Allergic to what \_\_\_\_\_  
 Other allergies Y/N Allergic to what? \_\_\_\_\_  
 Headaches Y/N \_\_\_\_\_  
 Other health problems \_\_\_\_\_  
 Current medication(s)/Vitamins \_\_\_\_\_  
 Have you had any operations? Y/N Kind? \_\_\_\_\_ When? \_\_\_\_\_  
 Do you use cigarettes/tobacco? Y/N \_\_\_\_\_ Alcohol? Y/N \_\_\_\_\_ Other Substance(s) Y/N \_\_\_\_\_  
 Name of family doctor \_\_\_\_\_ Date of last visit \_\_\_\_\_

**FAMILY HISTORY**

High blood pressure Y/N Relation \_\_\_\_\_ Diabetes Y/N Relation \_\_\_\_\_  
 Macular degeneration Y/N Relation \_\_\_\_\_ Retinal detachment Y/N Relation \_\_\_\_\_  
 Glaucoma Y/N Relation \_\_\_\_\_ Cataracts Y/N Relation \_\_\_\_\_  
 Other eye condition(s) What kind? \_\_\_\_\_ Relation \_\_\_\_\_

**PERSONAL EYE INFORMATION**

Have you had any eye operations? Y/N Type \_\_\_\_\_ Date \_\_\_\_\_  
 Have you had an eye injury? Y/N Kind \_\_\_\_\_ Date \_\_\_\_\_  
 Do you have glaucoma? Y/N Cataracts? Y/N Dry eyes? Y/N Blurred vision? Y/N  
 Other eye problems? Y/N What kind? \_\_\_\_\_  
 Do you wear glasses? Y/N Contact lenses? Y/N Type \_\_\_\_\_  
 Are you interested in wearing contacts? Y/N  
 Additional information \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Have any other members of your family been examined at this office? Y/N Name and relationship \_\_\_\_\_

*Payment is due when services are rendered and orders are placed.*

Who will pay this account? \_\_\_\_\_  
 Method of payment (*circle one*) Cash/ Check/ Credit Card

08/02 \_\_\_\_\_ Doctor's initials \_\_\_\_\_

\*Please date and initial if no changes \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_ ; \_\_\_\_\_