First Name	MI	Last Name	Sex	Birthdate	Age

Home Address	City	State	Zip	Home Phone	Daytime Contact Phone

Occupation	Employer	Referred By

PATIENT HISTORY

Name of your primary physician: ________________________________ Date of last medical exam: ______________

Have you had an eye examination at our office in the past? [] No [] Yes

Date of last eye examination: ______________ Previous optometrist: ____

Have your eyes been dilated at an eye examination before? [] No [] Yes How long ago? __________

List any medications you take: ____

Are you allergic to any medication? [] No [] Yes If yes, list: ____

List any eye injuries or surgeries you have had: ____

Do you smoke cigarettes? [] No [] Yes Drink alcohol? [] No [] Yes Use illegal substances? [] No [] Yes

Contact lens wearers only:

Which type of contact lenses do you wear? ________________________Average number of days per week wearing contacts: _____

Average wearing time per day (in hours): ______________________Contact lens solution brand: __________________________

If disposable lenses, frequency of disposal: ___________________________Age of current pair of contact lenses:______________

Do you currently, or have you ever had problems in the following areas:

	Yes	No	Office use only			Yes	No	Description and dates:
Migraines	[]	[]	346.00	V	Gastrointestinal	[]	[]	________________
Floaters in vision	[]	[]	379.24	E	Ear/Nose/Throat	[]	[]	________________
Flashes in vision	[]	[]	368.15	V	Cardiovascular	[]	[]	________________
Visual disturbance	[]	[]	368.10	V	Respiratory	[]	[]	________________
Visual blind spots	[]	[]	368.4_	V	Neurological	[]	[]	________________
Visual discomfort	[]	[]	368.13	V	Urinary	[]	[]	________________
Sudden visual loss	[]	[]	368.11	EVA	Muscles/Bones/Joints	[]	[]	________________
Eyestrain	[]	[]	368.13	V	Skin	[]	[]	________________
Light sensitivity	[]	[]	368.13	V	Endocrine (glandular)	[]	[]	________________
Visual halos	[]	[]	368.15	V	Blood/Lymph	[]	[]	________________
Amblyopia - "lazy eye"	[]	[]	368.0_	V	Allergic/Immunologic	[]	[]	________________
Glaucoma	[]	[]		VPG	Psychiatric	[]	[]	________________
Macular Degeneration	[]	[]		EVP	Diabetes	[]	[]	________________
Retinal Disease	[]	[]		EVP	Other	[]	[]	________________
Cataracts	[]	[]						
Other eye condition(s)	[]	[]	Describe:________________________					

FAMILY HISTORY

Please note any family history for the following conditions:

	No	Yes	?	Relation to you		No	Yes	?	Relation to you
Macular Degeneration	[]	[]	[]	________________	High Blood Pressure	[]	[]	[]	________________
Cataract	[]	[]	[]	________________	Diabetes	[]	[]	[]	________________
Retinal Disease	[]	[]	[]	________________	Heart Disease	[]	[]	[]	________________
Glaucoma	[]	[]	[]	________________	Kidney Disease	[]	[]	[]	________________
Arthritis	[]	[]	[]	________________	Thyroid Disease	[]	[]	[]	________________
Cancer	[]	[]	[]	________________	Other__________	[]	[]	[]	________________