Patient Information

Todays Date _____ Gender ☐ Male ☐ Female

Patient's Full Name_____ Email_____

DOB ____/____/_____ SSN _____ Please provide your email to access your individual patient portal.

Address_____

City/State _____ Zip _____ Occupation _____

Home Phone _____ Employer _____

Cell Phone _____ Hobbies _____

Work Phone _____ How did you hear about us? _____

Primary Physician _____ _____

Vision Insurance _____ Member ID _____ Group # _____
Policy Holder's Name _____ DOB ____/____/____ SSN _____

Medical Insurance _____ Member ID _____ Group # _____
Policy Holder's Name _____ DOB ____/____/____ SSN _____

Patient History

Do you experience any of the following? (please check all that apply)

☐ blurred vision ☐ double vision ☐ headaches ☐ itchy eyes ☐ eye pain

☐ eye strain ☐ dry eyes ☐ floaters ☐ flashes Other _____

Do you currently wear contact lenses? ☐ Yes ☐ No

If yes, are you having any problems with your lenses? _____

Do you or any of your blood relatives have any of the following? (please check all that apply)

	Self	Family	If yes for family please list family member
Macular Degeneration	☐	☐	_____
Glaucoma	☐	☐	_____
Diabetes	☐	☐	_____
High blood pressure	☐	☐	_____
High cholesterol	☐	☐	_____
Thyroid disorder	☐	☐	_____
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Heart Disease	☐	☐	_____

Please explain any other conditions not listed _____

Are you currently taking any medications, if yes please list: _____

_____

Are you allergic to any medications, if yes please list: _____

Do you have a history of any eye disease, injury, or surgery, if yes please list: _____

_____

Are you currently pregnant and/or nursing? (if applicable) ☐ Yes ☐ No

Social/Tobacco History (please check all that apply)

☐ Current smoker ☐ Former Smoker ☐ Never a smoker

☐ Alcohol use; if yes how much _____ ☐ Recreational Drug use

Patient/Guardian Signature _____ Date _____