Patient Information

Todays Date _____ Gender ☐ Male ☐ Female

Patient's Legal Name_____ Email_____

DOB ____/____/_____ Last 4 of SSN _____

Address_____

City/State _____ Zip _____ Occupation _____

Employer _____

Cell Phone _____ Hobbies _____

Work Phone _____ How did you hear about us? _____

Primary Physician _____ _____

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 Are you interested in contact lenses? _____

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 (or give us a copy): _____

_____

_____

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 ☐ Recreational Drug use

Patient/Guardian Signature _____ Date _____