Demographics

Name: _____ Date of Birth: _____ Sex: Male/Female

Address: _____ City/State: _____ Zip Code: _____

Home number: _____ Cell number: _____

E-mail: _____

Emergency Contact Person: _____ Contact number: _____

History

Current Weight: _____ Current Height: _____

Do you use cigarettes/tobaccos? No / Yes Alcohol? No / Yes

Other Substances? No / If yes, list: _____

Special visual needs for work, home or hobbies? If yes, explain: _____

Personal Ocular History

Date of Last Eye Exam/Dilation: _____ Reason for Today's Visit: _____

Do you wear glasses? No / Yes Do you currently wear contact lenses? No/ If yes, brand/type_____

Eye Operation(s)? No / If Yes, which type: _____ Date: _____

Eye Injury/Injuries? No / If Yes, describe type: _____ Date: _____

Do you have any of the following conditions?

☐ Cataracts ☐ Lazy Eye/Eye Turn ☐ Retinal Tear / Detachment ☐ Glaucoma

☐ Dry Eyes ☐ Macular Degeneration ☐ Red and/or Painful Eye ☐ Other:_____

Personal Health History

Allergic/Immunologic
- ☐ Allergies
- ☐ Lupus
- ☐ Clotting Disorder
- ☐ Other: _____

Cardiovascular
- ☐ Heart Disease
- ☐ High Cholesterol
- ☐ Hypertension
- ☐ Other: _____

Constitutional
- ☐ Weight Loss
- ☐ Other: _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid Disorder
- ☐ Other: _____

ENT
- ☐ Hearing Loss
- ☐ Other: _____

Integumentary/Skin
- ☐ Rash
- ☐ Herpes
- ☐ Other: _____

Musculoskeletal
- ☐ Arthritis
- ☐ Other: _____

Neurological
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Seizure Disorder
- ☐ Stroke
- ☐ Other: _____

Psychiatric
- ☐ Attention Disorder
- ☐ Depression
- ☐ Other: _____

Respiratory
- ☐ Asthma
- ☐ COPD
- ☐ TB
- ☐ Other: _____

Additional:
- ☐ Cancer, type:_____
- ☐ Other: _____

If female, are you currently pregnant? No/Yes Due Date: _____

Please List All Medications you are taking (including over the counter): _____

_____

Are you allergic to any medications No/ If Yes, please list: _____

Family Health/Ocular History: please mark positive history and indicate family relation

- ☐ Lazy Eye/Eye Turn:_____
- ☐ Glaucoma:_____
- ☐ Macular Degeneration:_____
- ☐ Retinal Tear / Detachment:_____
- ☐ Other:_____