

PATIENT INFORMATION

Name _____ Birth date _____ Date _____ Home Phone _____ Work Phone _____
Street Address _____ City/State _____ Zip Code _____ Other Phone _____
Social Security Number _____ Email Address _____
Occupation/Employer _____ Marital Status _____ Male Female Child
Parent/Guardian info (for patients under 15): Name _____ Relationship _____
Address/Phone (if different from above) _____
Emergency Contact: Name _____ Relationship _____ Phone _____

Main reason for todays visit _____
How did Learn about our Practice? Recommended by _____ Phone Book Insurance Company Advertisement
I Interested in or learning more about: Contact Lenses Sleeping in Contacts Colored Contacts
 LASIK ParagonCRT Corneal Reshaping Other _____

EYE HEALTH HISTORY

Date of last eye exam _____ By Doctor _____ I currently wear Glasses Soft CL's Gas Perm CL's
Age of Current glasses _____ I have had eye surgery for LASIK RK PRK Cataract Other _____
Age of Current CL's _____ Brand and Power if Known _____
CL Wearing Schedule _____ How often do you sleep in CL's _____
CL Replacement Schedule _____ Cleaning Solution _____

I have been diagnosed with:

- Cataracts _____
- Glaucoma _____
- Lazy Eye (Amblyopia) _____
- Retinal tear or Detachment _____
- Macular Degeneration _____
- Blindness or Loss of Vision _____
- Eye Allergies _____
- Eye Injury _____
- Other _____

I have a family history of: Please indicate parents, Grandparents, Siblings, Child

- Cataracts _____
- Glaucoma _____
- Lazy Eye (Amblyopia) _____
- Retinal tear or Detachment _____
- Macular Degeneration _____
- Blindness or Loss of Vision _____
- Other _____

What Eye drops do you use (RX & OTC) _____

MEDICAL HEALTH HISTORY

Primary Care Doctor _____ Office Phone Number _____ Date of Last Evaluation _____

ALL Current Medications _____

Allergies (including drug allergies) _____

Female Patients only: Are you currently Pregnant? Yes No Not Sure Are you currently nursing? Yes No

I have been diagnosed with:

- Diabetes How Long _____ Typical Blood sugar is _____
 Insulin Dependent Medication for _____
 Vision loss from or Retinopathy since _____
- High Blood Pressure Typical Pressure _____ controlled
- Heart Problems _____
- Respiratory Problems _____
- Brain disease or injury _____
- Headaches _____
- Cancer _____
- Arthritis _____
- Gastrointestinal _____
- Urogenital or Kidney disease _____
- Depression _____
- Blood disorders _____
- Mental disorders _____
- Thyroid Problems _____

- Hepatitis or Liver Disease _____
- High Cholesterol _____
- Tuberculosis _____
- Venereal disease _____
- Steroid treatment past present _____
- HIV positive or AIDS _____
- I use alcohol tobacco recreational substances _____
- Other _____

I have a family history of: Please indicate Parents, Grandparents, Siblings, Child

- Diabetes _____
- High blood pressure _____
- Heart Problems _____
- Respiratory Problems _____
- Cancer _____
- Other _____