

**PATIENT INFORMATION**

Name \_\_\_\_\_ Birth date \_\_\_\_\_ Date \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Street Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip Code \_\_\_\_\_ Other Phone \_\_\_\_\_  
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 \_\_\_\_\_

