

Patient Information

Name: _____ Date: _____

Address: _____ Phone: _____

_____ Work Phone: _____

Birth Date: _____ Occupation: _____

Guardian (if applicable): _____

Would you like a reminder card sent for your next exam? no yes

INSURANCE

Do you have vision care insurance? no yes Name and ID number: _____

Do you have health insurance? no yes Name and ID number: _____

Name of cardholder if different than patient: _____ Birthdate: _____

MEDICAL HISTORY

Do you have any allergies to medications? no yes If yes, explain: _____

List any medications you take: _____

List any of the following that you have had: crossed eyes, lazy eye, drooping eyelid, glaucoma, retinal disease, cataracts, eye infections or eye injury:

Do you wear glasses? no yes

Do you wear contact lenses? no yes Type of contact lenses: soft rigid

Family History: Please note any family history (parents, grandparents, siblings, children) for the following conditions.

Disease/Condition	NO	YES	Relationship To You
Blindness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Crossed Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>	_____
Retinal Detachment/Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____

