Patient History

Name: Dr. Mr. Miss Mrs. Ms. : _____

Address: _____

Birthdate: _____ SSN: _____ Phone: _____

Occupation/Grade: _____

Responsible Party: _____

Emergency Contact: _____

Medical Doctor (name and location):_____

Current Medications (you may bring a list to copy):_____

_____

_____

Are you a smoker? Y N

Please check any of the following conditions **you** have been diagnosed with:

___ Glaucoma ___ Cataracts ___ Blindness ___ Macular Degeneration ___ Diabetes

___ Arthritis ___ High Blood Pressure ___ Heart Disease ___ Asthma/Respiratory Conditions

___ Other Conditions:_____

Please check any of the following conditions a **family member** has been diagnosed with:

__ Cataracts __ Macular Degeneration __ Glaucoma __ Blindness __ Retinal Detachment

Please list any drug allergies: _____

Have you had any previous eye injuries or surgeries? Explain: _____

_____

Please check any of the following symptoms you experience: __ Problems with glare or reflections

__ Poor night vision __ Itchy or watery eyes __ Dry, burning, or gritty eyes __ Light sensitivity

__ Eyestrain with computer use, texting, or reading __ Poor comfort or soreness with your glasses

What form of vision correction do you currently use:

__ Nothing __ Full Time Glasses __Part Time Glasses __ Contact Lenses

How did you hear about our office? _____