Patient name_____ DOB_____ Date_____
Address_____ City_____ State_____ Zip_____
Home phone_____ Work phone_____ Occupation/Employer_____
Hobbies/Sports_____ Insurance_____
Method of payment today: (please circle) **Payment is required at time of service**
CASH CHECK VISA MASTERCARD DISCOVER

PLEASE MARK "S" FOR SELF OR "F" FOR FAMILY

____ diabetes
____ high blood pressure
____ heart disease
____ cancer
____ blindness
____ glaucoma
____ macular degeneration

PLEASE MARK ALL THAT APPLY TO YOU:

____ distance blur
____ near blur
____ trouble with glare
____ light sensitivity
____ double vision
____ flashing lights
____ floaters
____ itchy eyes
____ dry eyes
____ cataracts
____ retinal detachment
____ lazy eye
____ eye surgery
____ head/eye injury
____ high cholesterol
____ stroke
____ asthma
____ breathing problems
____ thyroid condition
____ seasonal allergies
____ immunologic disorder
____ HIV/AIDS
____ sexually transmitted disease
____ genitourinary disorder
____ pregnant/nursing (currently)
____ skin disorder
____ muscle or bone disorder
____ blood or lymph disorder
____ gastrointestinal disorder
____ unexplained fever/weight loss
____ ears,nose,mouth,throat disorder
____ psychiatric disorder
____ neurological disorder
____ migraines/headaches

Please list any other medical or vision problems _____

Please list any medications you are taking: (include birth control, hormones, over-the-counter, and vitamins)

_____

_____

Are you allergic to any medications? Please list_____

Do you drink alcohol? _____ If yes, how much and how many times per week?_____
Do you smoke? _____ If yes, how much?_____ How many years?_____

Date of last medical examination: _____ Physician's name (family doctor):_____

Date of last eye examination: _____ Doctor's name: _____
Have you ever worn contact lenses? _____ If yes, which brand?_____ Solution used:_____
Are you interested in contact lenses? _____ Are you interested in refractive surgery?_____

Authorization for treatment (*PATIENT SIGNATURE*):_____
(PARENT OR GUARDIAN SIGNATURE IF PATIENT UNDER 18)

NO REFUNDS ARE GIVEN FOR PROFESSIONAL SERVICES