PATIENT INFORMATION FORM

DATE_____ NAME_____

ADDRESS_____ SEX M_____ F_____

CITY_____ BIRTHDATE_____

STATE/ZIP_____ S.S. #_____

PHONE NUMBER _____

PRIMARY CARE MD _____

REASON FOR VISIT:_____

CIRCLE ALL THAT APPLY TO YOU:

GENERAL CHECK UP	BROKEN GLASSES	CONTACTS	BLURRED VISION
DOUBLE VISION	HEADACHES	SPOTS IN VISION	PAINFUL EYE
DRY EYE	CONCUSSION	ITCHY EYE	EYESTRAIN
LIGHT FLASHES	RED EYE	AMBLYOPIA (LAZY EYE)	GLAUCOMA
CATARACTS			

GENERAL HEALTH: CIRCLE ALL THAT APPLY:

HIGH BLOOD PRESSURE DIABETES THYROID HIGH CHOLESTEROL OBESITY
ARTHRITIS SLEEP DISORDER DEPRESSION/ANXIETY HEPATITIS
BLEEDING DISORDER HIV/AIDS KIDNEY DISEASE LIVER DISEASE LUNG DISEASE
LUPUS MIGRAINES MULTIPLE SCLEROSIS STROKE ENVIRONMENTAL ALLERGIES
ASTHMA

OTHER MEDICAL CONDITIONS NOT LISTED ABOVE_____

LIST FAMILY HISTORY OF ANY OF THE ABOVE CONDITIONS_____

_____

ALCOHOL USAGE: NONE____SOCIALLY_____MODERATELY_____ HEAVY_____

CIGARETTE SMOKING: NEVER_____FORMER_____
CURRENT SMOKER DAILY USAGE: 1 PACK 1/2 PACK 5 CIGARETTES LESS THAN 5

CURRENT MEDICATIONS_____

_____

MEDICATION ALLERGIES_____

FOR PEDIATRIC PATIENTS: CURRENT WEIGHT_____ BIRTHWEIGHT_____

ADHD/ADD: Y/ N AUTISM SPECTRUM: Y/ N PREMATURE?: Y/ N CROSSED EYES?: Y/ N

EMAIL IF AVAILABLE: