VISION AND MEDICAL HISTORY

Name: _____ Home Phone: ( )_____-_____

Address: _____ Work Phone: ( )_____-_____

City/State: _____ Cell Phone: ( )_____-_____

Zip Code: _____ Date of Birth: ____/____/_____

Social Security Number: _____-____-_____ Insurance: _____

Party Responsible for Bill: SELF OTHER – Name: _____

Phone #: ( )_____-_____ Address: _____

Emergency Contact: Name: _____ Phone: #: _____

E-mail Address: _____

Reason for Today's Exam: _____

Last Eye Exam: _____ Family Doctor: _____ Pharmacy:_____

Allergies: _____

Current Medications: _____

_____

_____

Please check any condition that applies to yourself or any members of your immediate family.

	Self	Family		Self	Family
Diabetes	____	____	Glaucoma	____	____
High Blood Pressure	____	____	Cataracts	____	____
Heart Problems	____	____	Macular Degeneration	____	____
Breathing Problems	____	____	Retinal Detachment	____	____
Thyroid Problems	____	____	Eye Surgery	____	____
Headaches	____	____	Lazy Eye	____	____
Cancer	____	____	Blindness	____	____
Double Vision	____	____	Bloodshot Eyes	____	____
Head/Eye Injury	____	____	Dry Eyes	____	____
Watery Eyes	____	____	Crossed Eyes	____	____
Floaters/Spots	____	____	Flashes of light	____	____
Itching Eyes	____	____	Temporary Vision Loss	____	____

Other ailments or diagnosis not listed above: _____

_____

Who may we thank for referring you? _____

Please circle any of the following that you would like more information about:

Diabetic Eye Disease Glaucoma Cataracts LASIK Macular Degeneration

Contact Lenses Transition lenses Progressive lenses Other: _____

Polarized lenses

DATE: _____ DR. INITIALS : _____ TECH INITIALS _____