Patient's Name: ____ Today's Date: ____/____/______

Primary Care Physician's Name: ____________________PH: ______________ Last physical: _________

Medical Information (please circle all that apply to patient)

Interested in Contact Lenses?	YES POSSIBLE NO	Interested in LASIK? YES POSSIBLE NO
Do you currently wear glasses?	YES NO If yes, what is the age of your current glasses?	
Do you currently wear contact lenses	YES NO If yes, what brand of contacts	

Cataract surgery YES NO	Eye muscle surgery YES NO	LASIK/PRK surgery YES NO
Retinal surgery YES NO	Traumatic eye injury YES NO	History of Eye Infections YES NO

<u>Vision History: Date of last eye exam_______________</u>

Do you or anyone in your immediate family have:

			Relation
Amblyopia/Lazy Eye	YES	NO	_______________
Blindness	YES	NO	_______________
Cataracts	YES	NO	_______________
Crossed/Turned Eyes	YES	NO	_______________
Diabetic Retinopathy	YES	NO	_______________
Dry Eyes	YES	NO	_______________
Flashes/Spots in vision	YES	NO	_______________
Glaucoma	YES	NO	_______________
Macular Degeneration	YES	NO	_______________
Retinal Detachment	YES	NO	_______________
Other	YES	NO	_______________

<u>List all current medications/Vitamins:</u>

<u>Drug Allergies</u> NO YES If Yes, list here:

<u>Allergens:</u>

Animal Dander YES NO

Environmental YES NO

Your Recent Medical history: Please circle all that apply to the patient.

Cardiovascular

Elevated Cholesterol	YES	NO
Heart Disease	YES	NO
High Blood Pressure	YES	NO
How long ________________		

Immunologic

Herpes Simplex(Eye)/Zoster	YES	NO
HIV Positive	YES	NO
Sarcoidosis	YES	NO
Ear, Nose, Throat	YES	NO

Respiratory

Asthma	YES	NO
COPD	YES	NO
Sleep Apnea	YES	NO

Constitution

Weight Loss or Gain	YES	NO
Diagnosed Cancer	YES	NO
If yes for self, Type______________		

Psychiatric

ADD	YES	NO
Anxiety Disorder	YES	NO
Depression or Bipolar	YES	NO

Musculoskeletal

Rheumatoid Arthritis	YES	NO
Osteoporosis	YES	NO

Endocrine

Thyroid	YES	NO
Diabetes _______yrs	YES	NO

Integumentary/Skin

Rosacea	YES	NO
Lupus	YES	NO

Gastrointestinal

Acid Reflux	YES	NO
Hepatitis A B C	YES	NO

Hematologic/Lymphatic

Anemia	YES	NO
Leukemia	YES	NO
Sickle Cell Trait/Disease	YES	NO

Genitourinary

Kidney Stones	YES	NO
Kidney/Bladder Disease	YES	NO
Sexually Transmitted Disease	YES	NO

Neurological

Headaches	YES	NO
Migraines	YES	NO
Seizures	YES	NO

<u>OTHER:</u>

Social History

Do you smoke NO YES, _____Packs/day

Alcohol Use NO YES, _____Drinks/wk

Females: Are YOU??

Pregnant: NO YES, ______weeks

Nursing NO YES