



PATIENT INFORMATION & MEDICAL HISTORY

Date _____

PATIENT INFORMATION

First _____ M.I. _____ Last _____

Address _____ City _____ State _____ Zip _____

Best Phone No _____ E-mail _____

May we text or e-mail you when your glasses are ready? ☐ Yes ☐ No

Preferred contact method: ☐ Call ☐ Text ☐ E-mail

Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Widowed

Date of birth _____ SSN _____ Spouse Name _____

Parent/guardian name(s), if patient is child _____

INSURANCE INFORMATION

Do you have insurance ☐ Yes ☐ No

Primary Cardholder _____ DOB _____

Relationship to Patient _____

Cardholder's Employer _____ Employer Phone _____

EYE-CARE HISTORY

Date of last medical exam _____ Date of last eye exam _____

Previous clinic / eye doctor's name _____

Primary physician / clinic _____

Do you wear glasses? ☐ Yes ☐ No How old are your present glasses? _____

Do you wear contact lenses? ☐ N/A ☐ Daily ☐ Weekly ☐ Monthly Brand _____

Do you get headaches? ☐ Yes ☐ No Does your neck get stiff? ☐ Yes ☐ No

EYE AND GENERAL HEALTH HISTORY

Any eye surgeries or injuries? ☐ Yes ☐ No If yes, please explain _____

Do you use eye drops? ☐ Yes ☐ No If yes, which drops and why? _____

Are you currently pregnant or nursing? ☐ Yes ☐ No ☐ N/A

Have you ever been diagnosed with?

Cataracts: ☐ Yes ☐ No When? _____

Glaucoma: ☐ Yes ☐ No When? _____

Macular degeneration: ☐ Yes ☐ No When? _____

Other Information _____

CURRENT MEDICATIONS - Please list each medication and what it is taken for. If none, write NONE

Medication

Taken For

ALLERGIES

Drug Allergies _____

Environmental Allergies _____

Physical reaction(s) to the allergies listed above _____

PERSONAL MEDICAL HISTORY (REVIEW OF SYSTEMS): - PLEASE CHECK IF ANY OF THE FOLLOWING APPLIES TO YOU. IF YOU HAVE NONE OF THESE CONDITIONS, PLEASE CHECK NONE.

Cardiovascular: ☐ None ☐ Hypertension ☐ Stroke ☐ Heart disease ☐ Vascular disease ☐ Other	Endocrine: ☐ None ☐ Non-Insulin dependent diabetes ☐ Insulin dependent diabetes ☐ Thyroid Problem ☐ Hormonal dysfunction ☐ Other	Respiratory: ☐ None ☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ COPD ☐ Other
Constitutional: ☐ None ☐ Cancer ☐ Trauma /Large-volume blood loss ☐ Developmental disability ☐ Other	Psychiatric: ☐ None ☐ ADHD ☐ Depression ☐ Schizophrenia ☐ Other	Dermatologic: ☐ None ☐ Eczema ☐ Rosacea ☐ Psoriasis ☐ Other
Neurological: ☐ None ☐ Multiple sclerosis ☐ Epilepsy ☐ Cerebral palsy ☐ Tumor ☐ Other	Musculoskeletal: ☐ None ☐ Osteoarthritis ☐ Fibromyalgia ☐ Muscular dystrophy ☐ Ankylosing spondylitis ☐ Other	Immunologic: ☐ None ☐ AIDS or HIV ☐ Rheumatoid arthritis ☐ Lupus ☐ Neurofibromatosis ☐ Other
Hematological: ☐ None ☐ Anemia ☐ Leukemia ☐ Other	Gastrointestinal: ☐ None ☐ Crohn's disease ☐ Colitis ☐ Other	Ear / Nose / Throat: ☐ None ☐ Hearing loss ☐ Upper respiratory infection ☐ Other

Alcohol use: ☐ Yes ☐ No **Tobacco use:** ☐ Yes ☐ No

FAMILY HISTORY

Has anyone in your family (grandparents, parents, siblings, or children; living or deceased) been diagnosed with:

Glaucoma	☐ Yes	☐ No	_____	High blood pressure	☐ Yes	☐ No	_____
Cataracts	☐ Yes	☐ No	_____	Diabetes	☐ Yes	☐ No	_____
Blindness	☐ Yes	☐ No	_____	Cancer	☐ Yes	☐ No	_____
Macular Degeneration	☐ Yes	☐ No	_____	Heart disease	☐ Yes	☐ No	_____
Crossed Eyes	☐ Yes	☐ No	_____	Thyroid disease	☐ Yes	☐ No	_____
Retinal Detachment	☐ Yes	☐ No	_____	Lupus	☐ Yes	☐ No	_____

Other family history _____