Date: ____/____/_____

Patient Name: _____

DOB: _____/_____/_____

Height: _____

Weight: _____

When was your last eye exam? _____

Do you currently have prescription eyeglasses?

[ ] *No* [ ] *Yes*

Do you currently wear contact lenses?

[ ] *No* [ ] *Yes* [ ] *I am interested in wearing contacts*

Are you using any ***eye medications*** *today?*

[ ] *No* [ ] *Yes - please describe.*_____

Have you ever had an eye injury?

[ ] *No* [ ] *Yes - please describe.*_____

Have you ever had any eye surgeries?

[ ] *No* [ ] *Yes - please describe.*_____

Do you have any environmental allergies, such as pollen?

[ ] *No* [ ] *Yes - please describe.*_____

Do you have any medication allergies?

[ ] *No* [ ] *Yes - please describe.*_____

Do you smoke?

[ ] *Never* [ ] *Previous* [ ] *Current*

For women, are you currently pregnant or nursing?

[ ] *No* [ ] *Yes*

Have you or anyone in your family (grandparents, parents, siblings, children) been diagnosed with:

	Self	***Family Member (please explain relation)***
Cataracts:	[ ]	[ ] _____
Retinal Detachment:	[ ]	[ ] _____
Glaucoma:	[ ]	[ ] _____
Lazy Eye or Amblyopia:	[ ]	[ ] _____
Macular Degeneration:	[ ]	[ ] _____
Eye Turn or Strabismus:	[ ]	[ ] _____
Dry Eyes:	[ ]	[ ] _____
Loss of Vision:	[ ]	[ ] _____
Any other eye problems	[ ]	[ ] _____

Please list any medication that you are taking or ask our staff to make a copy of your medication list. (Including vitamins, herbs, supplements and over the counters):

1. _____ *2.* _____

3. _____ *4.* _____

5. _____ *6.* _____

7. _____ *8.* _____

9. _____ *10.* _____

Personal Medical History: *Please check and circle if any of the following applies to you. Please write in any condition(s) not listed. If you have none of these conditions, please check none.*

None	***Yes***	
[ ]	[ ]	***Cardiovascular****: High Blood Pressure, High Cholesterol, Heart Disease*
[ ]	[ ]	***Endocrine****: Diabetes, Thyroid problem, Hormone Dysfunction, PituitaryDisorder*
[ ]	[ ]	***Respiratory****: Asthma, COPD, Emphesema*
[ ]	[ ]	***Psychiatric****: ADHD,Depression, Anxiety, Bipolar, Schizophrenia*
[ ]	[ ]	***Neurological****: Multiple Sclerosis, Seizures, Headaches Disorder*
[ ]	[ ]	***Musculoskeletal****: Arthritis, Fibromyalgia, Anklosing Spondylitis*
[ ]	[ ]	***Immunological****: Lupus, Shingles, AIDS or HIV*
[ ]	[ ]	***Constitutional****: Cancer, Developmental Disability*
[ ]	[ ]	***Hematological****: Anemia, Leukemia*
[ ]	[ ]	***Gastrointestinal****: Crohn's, Celiac's, Colitis, Acid Reflux*
[ ]	[ ]	***Ear/Nose/Throat****: Hearing Loss, Sinus Infection, Vertigo, Meniere's*
[ ]	[ ]	***Dermatologic****: Excema, Rosacea, Psoriasis, Skin Cancer*
[ ]	[ ]	*Other:* _____

Family Medical History: *Has anyone in your immediate family been diagnosed with:*

No	***Yes***	
[ ]	[ ]	*High Blood Pressure and/or High Cholesterol*
		Who: _____
[ ]	[ ]	*Heart or Vascular Disease*
		Who: _____
[ ]	[ ]	*Diabetes*
		Who: _____
[ ]	[ ]	*Thyroid problem*
		Who: _____
[ ]	[ ]	*Multiple Sclerosis*
		Who: _____
[ ]	[ ]	*Migraines/Headaches Disorder*
		Who: _____
[ ]	[ ]	*Lupus*
		Who: _____
[ ]	[ ]	*Shingles*
		Who: _____
[ ]	[ ]	*Skin Cancer*
		Who: _____