Name: ________________ DOB: ________ Current Age: ______

SS #: ________________ Height: ______ Weight: ______ Sex: M ____ F ____

Current Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Home Address: ________________________________

Home Phone #: ________________ Cell Phone #: ________________

Insurance Name: ________________ Member ID: ________________

PCP Name: ________________ PCP Phone #: ________________

Pharmacy Name: ________________ Pharmacy Phone #: ________________

Reason for today's visit: ________________________________

Are you currently experiencing any of the following: (Please mark all that apply)							
Blurry/Decreased Vision		Eye Injury		Growth/Bump on Lid		Watery Eyes	
Double Vision		Eye Pain/Burning		Headaches		Other:	
Droopy Lid		Flashes of light/Floaters		Itchy Eyes/Lids			
Dry Eyes		Glare/Light Sensitivity		Red Eye(s)			
Past Ocular History: (Please mark all that apply)							
NONE		Dry Eyes		Macular Degeneration		Other:	
Amblyopia (Lazy Eye)		Glaucoma		Optic Neuritis			
Cataracts		Iritis		Retinal Detachment			
Diabetic Retinopathy		Keratoconus					
Ocular Surgeries: (Please mark all that apply)							
NONE		Foreign Body Removal		Punctal Plugs		Other:	
Blepharoplasty (lid surgery)		Glaucoma Laser Surgery		Retinal Laser (Diabetes)			
Cataract Surgery		LASIK/PRK/RK		Strabismus Surgery (Eye Muscle Surgery)			
Corneal Transplant		Ptosis Repair					
Medical Illnesses: (Please mark all that apply)							
NONE		Headaches/Migraines		MRSA		Other:	
Asthma		Heart Attack		Multiple Sclerosis			
Bell's Palsy		Herpes Simplex		Myasthenia Gravis			
Brain Tumor		HIV+/AIDS		Osteoarthritis			
Cancer		Hypertension		Rheumatoid Arthristis			
CHF		Hyperthyroidism		Seizures			
COPD/Emphysema		Hypothyroidism		Sickle Cell			
Depression		Lung Disease		Stroke			
Diabetes		Meningitis		TIA			

Please continue on the back side of this page

Family History: (Please mark all that apply)							
Blindness		Eye Misalignment		Lazy Eye (Amblyopia)		Other:	
Cancer		Glaucoma		Macular Degeneration			
Cataracts		Heart Disease		Retinal Detachment			
Diabetes		Hyperthyroidism					

Allergies: (Please list known drug/environment/food allergies you have)		
Latex		Other:
Penicillin		

Systemic Medications: (Please list all OTC/prescription medications you take, including strengths/dosages)
Please see list provided (Please provide list on separate page)

Ocular Medications: (Please list all eye medications you take including strengths/dosages)

General Surgeries/Operations: (Please include dates performed and request separate page if necessary)

Social History:					
Do you smoke? Y____ N____ Packs/Day____ Have you ever smoked? Y____ N____ Packs/Day____					
Do you drink alcohol? Y____ N____ Glasses/Bottles per day/week____				**Drug Use? Y____ N____** Frequency: Daily Weekly Occasionally	
Occupation:____					
Hispanic		**Non-Hispanic**		**Other**	
American Indian/Alaskan		**Asian**		**Black/African American**	
Caucasian		**Hawaiian/Pacific Islander**		**Unknown**	

____ ______________________

Patient or Parent/Guardian Signature **Date**