Name _____ Today's Date _____
Last First MI

Date of birth _____ Social Security Number_____

Address _____

City _____ State _____ Zip _____

E-mail _____ Best phone #_____

Are you: □ Married □ Widowed □ Single □ Minor □ Separated □ Divorced

Employer / School _____ Occupation _____

Emergency Contact _____ Phone _____

**Responsible Party name**: (□ check here if same as above) _____ Date of birth_____

Address: _____ Phone: _____

**Vision Plan Information:** Name of plan _____ Member or Subscriber ID:_____

Name of policy holder_____ Policy holder DOB: _____

Last 4 of policy holder's SSN: _____ Phone number of policy holder: _____

**Medical Ins. Information:** Name of plan _____ Member or Subscriber ID:_____

Name of policy holder_____ Policy holder DOB: _____

Last 4 of policy holder's SSN: _____ Phone number of policy holder: _____

**PERSONAL HEALTH HISTORY**

Please list any prescription medications you take:_____

_____

Are you allergic to any medications?: □ Y □ N If yes, please list:_____

Do you have a history of any of the following?

□ Glaucoma □ Macular degeneration □ Cataracts □ Dry eye □ Lazy Eye
□ Retinal detachment □ Eye injury □ Eye surgery: _____ □ Other_____

Do you smoke or use tobacco? □ Y □ N

Do you currently wear glasses? □ Y □ N □Full time □Part time □Distance □Reading

Do you currently wear contact lenses? □ Y □ N

Current brand of contacts? _____ Do you sleep with them in? □ Y □ N □ Sometimes

**CHECK YES OR NO FOR THE EACH OF THE FOLLOWING REGARDING YOUR HEALTH HISTORY:**

| | YES | NO | DETAILS |
|---|---|---|---|
| General (fever, weight loss/gain) | □ | □ | _____ |
| Ear/Nose/Throat (hearing loss, stuffy nose, cough) | □ | □ | _____ |
| Cardiovascular (high BP, irregular heartbeat) | □ | □ | _____ |
| Respiratory (congestion, wheezing, short of breath) | □ | □ | _____ |
| Gastrointestinal (diarrhea, ulcers, constipation) | □ | □ | _____ |
| Kidney/Bladder/Genital (painful/frequent urination) | □ | □ | _____ |
| Muscles/Bones/Joints (arthritis, stiffness) | □ | □ | _____ |
| Skin (warts, growths, rash) | □ | □ | _____ |
| Neurological (numbness, headache, seizures) | □ | □ | _____ |
| Psychiatric (anxiety, depression, insomnia) | □ | □ | _____ |
| Endocrine (diabetes, hypothyroid, hyperthyroid) | □ | □ | _____ |
| Blood/Lymph (bleeding, high cholesterol) | □ | □ | _____ |
| Allergic/Immunologic (swelling, itching, lupus) | □ | □ | _____ |
| Females: Are you pregnant or nursing? | □ | □ | _____ |

**FAMILY HEALTH HISTORY**

Does anyone in your family (mother, father, grandparent, siblings) have any of these conditions?

| | Who | | Who |
|---|---|---|---|
| Macular degeneration | □ _____ | Diabetes | □ _____ |
| Glaucoma | □ _____ | High Blood Pressure | □ _____ |
| Other eye disease? | □ _____ | Cancer | □ _____ |

_____ _____
Patient's Signature Date