

Full Legal Name _____ Nickname _____

Address _____ Mr Mrs Ms Miss Dr _____

City/State _____ Zip Code _____

Home Phone _____ Work Phone _____ Cell _____

Occupation _____ Grade _____ Birth date _____ Email _____

May we contact you by email for office communication? Yes No

Who may we thank you for your referral? _____

Who is responsible for payment? _____

Do you have: Vision Insurance _____ No

Medical Insurance _____ No

Medical and Eye History

When was your last eye exam?					
Do you wear:	Glasses	Contacts	Neither		
Are you interested in:	Contact Lenses	Laser Vision Correction	Sunglasses	Computer Glasses	
Do you have:	Diabetes	High Blood Pressure	Heart Disease	Respiratory Disease	
	Thyroid Disease	Psychiatric Care	Cancer	Skin Disorder	Allergies
Other:					
					None
List your medications:					None
List any medication you are allergic to:					None
Do you smoke tobacco products daily?			Yes	No	
Did you smoke tobacco products daily in the past?			Yes	No	
Do you use any eye drops?	Please list:				None
Have you ever had:	Eye Injury	Eye Surgery	Eye Disease	Cataracts	Pink Eye
	Lazy Eye	Cataract Surgery	Glaucoma	Floaters	
	Dry Eyes	Macular Degeneration	Crossed Eye	Retinal Disease	
Does anyone related to you have:	Diabetes	High Blood Pressure	Glaucoma	Macular Degeneration	