Name_____ DOB_____ SSN#_____

Family Physician_____ Marital Status: M/S/D/W Occupation_____ FT/PT

When was your last Eye health exam_____

PATIENT MEDICAL HISTORY

Allergies:	Allergies/Hay Fever.....Yes/No	Head/Neck:	Frequent Headaches…….Yes/No
Cardiovascular:	Heart Disease.....Yes/No		Sinusitis.....Yes/No
	High Blood Pressure.....Yes/No	Hematologic:	Breast Cancer.....Yes/No
	Stroke.....Yes/No	Immunologic:	Chicken Pox.....Yes/No
	High Cholesterol.....Yes/No	Integumentary:	Skin Problems.....Yes/No
Constitutional:	Weight Gain/Loss.....Yes/No		Skin Cancer.....Yes/No
	Dizzy/Fainting.....Yes/No	Musculoskeletal:	Arthritis.....Yes/No
Endocrine:	Diabetes.....Yes/No		Rheumatoid Arthritis.....Yes/No
	Do you use insulin.....Yes/No	Neurological:	Seizures.....Yes/No
	Thyroid Problems.....Yes/No		Migraines.....Yes/No
Gastrointestinal:	Intestinal Problems.....Yes/No	Psychiatric:	Depression.....Yes/No
	Acid Reflux.....Yes/No		Anxiety.....Yes/No
Genitourinary:	Kidney Problems.....Yes/No	Respiratory:	Asthma.....Yes/No

Other Health Problems (please specify)_____
Do you smoke?.....Yes/No How much per day?_____

OCULAR HISTORY

Cataracts……Yes/No Have you had cataract surgery……..Yes/No
Glaucoma……Yes/No Do you use any prescription eye drops?.....Yes/No
Have you had any eye injuries?.....Yes/No
Have you had any other eye surgeries or lasers?(Lasik, PRK, Strabismus, etc.)specify_____

MEDICINES

Please list all current medications including tablets, injections, birth control, hormones and antihistamines
_____

Please list any medication allergies? (Sulfa, Penicillin, etc.)_____

FAMILY HISTORY

Glaucoma……..Yes/No	Mother	Father	Brother	Sister
Blindness……..Yes/No	Mother	Father	Brother	Sister
Diabetes……Yes/No	Mother	Father	Brother	Sister
Macular Degeneration…….Yes/No	Mother	Father	Brother	Sister

Authorization: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the eye doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such eye care to third party and/or health practitioners. I authorize and request my insurance company to pay directly to the eye doctor insurance benefits otherwise payable to me. I understand that my eye care insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Patient or Parent Signature (if minor)_____ Date_____