Please take a moment complete the vital information on ***both sides***. If you have any questions or need clarification, please ask your receptionist or technician. ***If you need extra paper for any section below, please ask your receptionist***.

First Name: ________________________________ Last Name: ____
Today's Date: _______________Date of Birth: ______________ Height: ___ ft. ___ in. Weight: _____lbs
Primary Care Physician: ____________________________ Last physical exam: ________________________
Preferred Pharmacy: ______________________________ Currently Pregnant or Breast Feeding? **Y or N**
How did you hear about us? *Please check one:*
□ Friend or Relative □Insurance Provider □ Co-Worker □ Internet Search □ Social Media □Other ___________

MEDICATIONS: Please list any **prescribed** and **over-the-counter** medications you are taking along with dosage.

____

____

□ **None** □ **See attached list**

ALLERGIES: Please list all medications that you are allergic or sensitive to:

____

____

□ **None** □ **See attached list**

ALLERGIES (OTHER):
□ Latex □ Iodine
□ Seasonal □ Food (please list)____
□ Anesthetic □ Chemical (please list)____

PAST MEDICAL HISTORY:
Within the last five years, please list any:
Prior Hospitalizations: ____
Prior illnesses: ____
Prior surgeries/operations: ____
□ **None** □ **See attached list**

OPTHAMOLOGY SURGERY HISTORY:
Please list all prior eye surgeries. Please include date of surgery and name of surgeon:

____

____

□ **None** □ **See attached**

PAST OCULAR HISTORY:
Eye-Care Professional's name: _____________________________ Last eye exam: ___________________________
Please check all that apply:
□ Glaucoma □ Corneal Problem □ Macular Degeneration □ Amblyopia (lazy eye)
□ Cataracts □ Retinal Problem □ Blindness □ Strabismus (crossed eyes) □ Trauma
□ **None**

SOCIAL HISTORY:
Alcohol use: □ Yes (Drinks per day ___________) □ No
Smoker: □ Yes (current): cigarettes/day □ Yes (past) □ Never smoked
Annual flu shot/Influenza vaccine □ Yes □ No
Occupation: ______________________________ Employer: ____
Hobbies: ____
____

REVIEW OF SYSTEMS: Please list your ***current*** health problems. Check all that apply:

General/Constitutional: □ Fever □ Weight Loss

Skin and/or Breast: □Psoriasis □Eczema □Rosacea □Breast Cancer □Chemo □Radiation

Ears: □Hearing Loss

Nose: □Sinusitis

Mouth/Throat: □Mouth/Tooth Abscess

Thyroid: □Hypothyroid □Hyperthyroid

Respiratory: □ Asthma □ Emphysema □ COPD □Chronic Bronchitis

Cardiovascular: □High Blood Pressure □Heart Disease □High Cholesterol □Pacemaker

Digestive: □Ulcer □Chron's and/or Colitis □Reflux/GERD

Urinary: □Kidney/Bladder disease □STD □Cancer/Radiation/Chemo □Contraceptives/Hormones

Musculo-skeletal: □Arthritis □Osteoarthritis □Fibromyalgia □Muscle Disorders

Neurological: □Headaches/Migraines □Seizures □Stroke □Multiple Sclerosis □Dementia

Endocrine: □Pre-Diabetes □ Type 1 Diabetes □ Type 2 Diabetes

Blood/Lymph: □Anemia □Leukemia

Psychiatric: □ADD/ADHD □Anxiety □Depression □Bi-polar □Schizophrenia

Allergic/Immunologic: □Allergies □Lupus □Rheumatism □Sarcoid

Other: ____

□ **None of the above**

FAMILY HISTORY: Please check all that apply and list the family member affected:

□ Glaucoma ____________________________________
□ Macular Degeneration __________________________
□Strabismus (Crossed Eyes)________________________
□Amblyopia (Lazy Eye)____________________________
□ Retinal Detachment _____________________________
□ Blindness ____________________________________

□High Blood Pressure ___________________________
□ Heart Disease________________________________
□ High Cholesterol ______________________________
□ Diabetes ____________________________________
□ Migraines ___________________________________

□**None of the above**