TO BE COMPLETED BY PATIENT

Date ___/___/______

Name ____ Nickname________________
(Last) (First) (M.I.)

Local Mailing Address_______________________________________ ___________ Zip__________
(Street) (City) (State)

Other Address____ ___________Zip__________
(Street) (City) (State)

Email Address____ Preferred: ☐ email/ ☐ mail

Phone (Hm):(____)_____-___________, (Wk):(____)_____-____________, (Cell):(____)_____-___________

Preferred Phone: ☐ Home / ☐ Work / ☐ Cell (Text OK? Y__, N__), Primary Doctor: __________________

Preferred Language ☐ English, ☐ Spanish, ☐ Other Ethnicity: ☐ Hispanic or Latino, ☐ Not Hispanic or Latino

Soc. Sec.# __ __ __-__ __-__ __ __ __ Birth date ___/___/______ Male ☐ / Female ☐

Spouse Name:____________________ Unmarried ☐

Spouse Birth Date___/___/______

Other Family Members Living At Home	Age	Relationship

☐ NONE

Medications and Dosage None ☐

Ex. Aspirin 81 mg once daily

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If more space is needed, please attach list ☐

ANY KNOWN MEDICATION ALLERGIES: NONE ☐

____

____

FAMILY HEALTH HISTORY

Unknown History (i.e., adopted) ☐

Relationship

Does/Did Any Blood Relative Have…..?

			Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	Y	N	F	M	B	Sis	Son	D
Macular Degeneration	Y	N	F	M	B	Sis	Son	D
Other Eye Disorder	Y	N	F	M	B	Sis	Son	D
Cancer	Y	N	F	M	B	Sis	Son	D
Diabetes	Y	N	F	M	B	Sis	Son	D
High Blood Pressure	Y	N	F	M	B	Sis	Son	D
Thyroid Abnormality	Y	N	F	M	B	Sis	Son	D
Other________________	Y	N	F	M	B	Sis	Son	D
Other________________	Y	N	F	M	B	Sis	Son	D
Other________________	Y	N	F	M	B	Sis	Son	D
Other________________	Y	N	F	M	B	Sis	Son	D

Race:

- ☐ American Indian
- ☐ Alaskan Native
- ☐ Asian
- ☐ African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Caucasian
- ☐ Other

PLEASE CONTINUE ON BACK

PERSONAL HEALTH HISTORY

PLEASE INDICATE ANY MEDICAL CONDITIONS IN THE FOLLOWING AREAS

CONSTITUTION
(e.g. Developmental Disability, Cancer, Chills, Fatigue, Fever, Insomnia, Weight Loss/Gain, Other)______________________________
☐ NONE

EARS, NOSE AND THROAT
(e.g. Hearing Loss, Sinusitis, Dry Mouth, Laryngitis, Oral Herpes, Other)______________________________
☐ NONE

NEUROLOGICAL
(e.g. MS, Epilepsy, Cerebral Palsy, Tumor, Stroke, Migraines, Seizures, Autism, Other)______________________________
☐ NONE

PSYCHIATRIC
(e.g. Depression, ADHD, Anxiety/ Panic Attacks, Nervousness, Bipolar, Dementia, Other)______________________________
☐ NONE

CARDIOVASCULAR
(e.g. High Blood Pressure, Stroke, Heart Disease, Vascular Disease, Congestive Heart Failure, Other)______________________________
☐ NONE

RESPIRATORY
(e.g. Asthma, Bronchitis, Emphysema, COPD, Sleep Apnea, TB, Other)______________________________
☐ NONE

GASTROINTESTINAL
(e.g. Crohn's, Colitis, Ulcer, Acid Reflux, GERD, Celiac Disease, Diarrhea, Hernia, Other)______________________________
☐ NONE

GENITOURINARY
(e.g. Prostate, Kidney, STD, Pregnant, Herpes, Chlamydia, Uterine, Nursing, Ovaries, Testicles, Bladder, Other)______________________________
☐ NONE

MUSCULOSKELETAL
(e.g. Arthritis, Fibromyalgia, Osteoporosis, Gout, Neck Pain, Back Pain, Other)______________________________
☐ NONE

INTEGUMENTARY
(e.g. Eczema, Rosacea, Psoriasis, Herpes Simplex, Shingles, Dermatitis, Skin Rash, Other)______________________________
☐ NONE

ENDOCRINE
(e.g. Diabetes, Hypothyroidism, Graves Disease, Goiter, Hypoglycemia, Hormonal Dysfunction, Other)______________________________
☐ NONE

HEMATALOGIC/LYMPHATIC
(e.g. Anemic, Large Volume Blood Loss, High Cholesterol, Lymphoma, Other)______________________________
☐ NONE

ALLERGIC/IMMUNOLOGIC
(e.g. Allergies, Rheumatoid Arthritis, Lupus, Sjogren's, Disease, HIV, Immune Disorder, Other)______________________________
☐ NONE

SOCIAL HABITS:
TOBACCO: ☐ NEVER A SMOKER / ☐ QUIT SMOKING AT AGE____ / ☐ SMOKER: ____ PACKS PER DAY
ALCOHOL: ☐ NON-DRINKER / ☐ <1U/DAY / ☐ 1-2U/DAY / ☐ 3-6U/DAY / ☐ 7-9U/DAY / ☐ >9U/DAY / ☐ DRY ALCOHOLIC
OTHER: ☐ NO DRUG USE / ☐ MARIJUANA / ☐ OTHER: ______________________________

OTHER
(e.g. Head Injury, Accidents, Other)______________________________
☐ NONE

OCULAR HEALTH HISTORY

DO YOU HAVE ANY PROBLEMS IN THESE AREAS?

			How long?
GLAUCOMA	Y	N	________
CATARACTS	Y	N	________
MACULAR DEGENERATION	Y	N	________
EYE INJURY	Y	N	________
RETINAL DISEASE	Y	N	________
OTHER EYE DISEASE	Y	N	________
BLINDNESS	Y	N	________
STRABISMUS (crossed eyes)	Y	N	________
AMBLYOPIA (lazy eye)	Y	N	________
DIABETIC RETINOPATHY	Y	N	________
DRY EYE	Y	N	________
OTHER EYE PROBLEM	Y	N	______________________________

Please check all that apply:

GLASSES: ☐ NONE / ☐ FULL TIME / ☐ PART-TIME

SAFETY GLASSES	________
PRESCRIPTION SUNGLASSES	________
NON-PRESCRIPTION SUNGLASSES	________
COMPUTER GLASSES	________
GLASSES/READERS (over the counter)	________
GLASSES/READING (prescription)	________
CONTACT LENSES/DAILY WEAR	________
CONTACT LENSES/EXTENDED WEAR	________
CONTACT LENSES/MONOVISION	________
CONTACT LENSES/MULTIFOCAL	________

SURGICAL HISTORY

PROCEDURE NAME/TYPE	NONE ☐	Date of Procedure
______________________________		________________
______________________________		________________
______________________________		________________