LAST NAME_____ FIRST NAME_____ MIDDLE INITIAL ____

DR MR MRS MISS MS

PATIENT HISTORY & INFORMATION

(Confidential information for our files)

HOME PHONE _____

BUSINESS PHONE _____ EXT._____

TODAY'S DATE_____

CELL PHONE_____

SEX MALE FEMALE (Please Circle One) AGE_____ DATE OF BIRTH_____

E-MAIL ADDRESS _____

STREET ADDRESS_____ CITY_____ STATE_____ ZIP _____

EMPLOYER_____ OCCUPATION _____

BUSINESS ADDRESS _____

SPOUSE'S NAME_____ OCCUPATION_____ EMPLOYED BY _____

PHYSICIAN_____ ADDRESS _____

PHYSICIAN PHONE NUMBER_____ MAY WE SEND A REPORT TO YOUR PHYSICIAN? _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON FINANCIALLY RESPONSIBLE _____

DO YOU HAVE ANY HISTORY OF THE FOLLOWING? (IF YES, PLEASE CHECK)

____HIGH BLOOD PRESSURE____EAR TROUBLE____DIABETES____ASTHMA____ANEMIA____TUBERCULOSIS____BLOOD DISEASE

____KIDNEY OR LIVER INVOLVEMENT____CANCER____ARTHRITIS____HEART TROUBLE____RHEUMATIC FEVER____AIDS/HIV

____HEPATITIS (TYPE_____) OTHER (PLEASE SPECIFY)_____

DOES ANYONE IN YOUR FAMILY HAVE OR HAD ANY OF THE FOLLOWING? (IF YES, PLEASE CHECK)

____DIABETES____HEART DISEASE____HIGH BLOOD PRESSURE____BLINDNESS____EYE DISEASE____STRABISMUS(turned eye)

____AMBLYOPIA(lazy eye)____GLAUCOMA____CATARACTS

ARE YOU SENSITIVE OR ALLERGIC TO MEDICATION OR ANESTHETICS?_____ IF YES, SPECIFY _____

ARE YOU UNDER A DOCTOR'S CARE?_____ WHY? _____

ARE YOU TAKING ANY MEDICATIONS?_____ FOR WHAT PURPOSE?_____

LIST MEDICATION NAME(S) _____

ARE YOU TAKING ANY HORMONES, INCLUDING BIRTH CONTROL PILLS? _____

HAVE YOU EVER HAD EYE SURGERY?_____ EYE DISEASE?_____ EYE OR HEAD INJURY?_____

ARE YOU PRESENTLY WEARING CONTACT LENSES?_____ NAME OF CONTACT LENS BRAND _____

HAVE YOU EVER WORN CONTACT LENSES?_____ ARE YOU INTERESTED IN WEARING CONTACT LENSES?_____

DATE OF LAST VISUAL EXAM_____ EXAMINING DOCTOR_____ WERE GLASSES GIVEN?_____