

PATIENT INFORMATION

NAME _____ (M) (F) PHONE _____ W _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
SOCIAL SECURITY # _____ DATE OF BIRTH _____ AGE _____
OCCUPATION _____ EMPLOYER _____ PHONE _____
NAME & ADDRESS OF NEAREST RELATIVE _____ PHONE _____
PRIMARY CARE PHYSICIAN _____
PHYSICIAN'S ADDRESS _____
REFERRED BY _____

EYE HISTORY

WHAT IS THE REASON FOR THE VISIT _____

DO YOU WEAR GLASSES FOR DISTANCE VISION? _____ FOR READING? _____

ARE YOU CURRENTLY DRIVING? _____ DAY _____ NIGHT _____

HAVE YOU EVER BEEN TOLD YOU HAVE: GLAUCOMA? _____ CATARACTS? _____ ANY EYE DISEASE? _____

DO YOU HAVE A FAMILY HISTORY OF: GLAUCOMA? _____ CATARACTS? _____ ANY EYE DISEASE? _____

LIST ANY EYE CONDITION FOR WHICH YOU WERE TREATED _____

DO YOU HAVE OR HAVE EVER HAD: A SERIOUS EYE INJURY? YES _____ NO _____

EYE SURGERY? YES _____ NO _____

CONTACT LENSES? YES _____ NO _____

DO YOU HAVE ANY ALLERGIES? _____ IF YES, WHAT ARE YOU ALLERGIC TO _____

LIST ANY MEDICAL CONDITION FOR WHICH YOU ARE OR HAVE BEEN TREATED _____

DO YOU DRINK ALCOHOL? _____ HOW OFTEN? _____ DO YOU SMOKE? _____ HOW MUCH? _____

PLEASE LIST NAMES OF MEDICATIONS YOU ARE CURRENTLY TAKING: _____

PLEASE LIST ALL MAJOR ILLNESSESS AND INJURIES _____

DATE _____