Patient History

Referring Doctor: ____________________

Contact Information

First Name:		SS#:	Age:	DOB:	Gender: M F
Last Name:			Best?	Home Phone:	
Address:			Best?	Work Phone:	
City:	State:	Zip:	Best?	Cell Phone:	
Employer:		Marital Status:	E-Mail:		
Occupation:		Who can we thank for your referral?			

Medical History

Do you have **any** allergies? If yes, explain:

List any medications you take (including oral contraceptives and over the counter):

Are you currently being treated for any medical condition? If yes, explain:	Yes	No
Past surgeries?(please list)		
Are you pregnant or nursing?	Yes	No
Do you smoke? (If so how much)	Yes	No

Have you ever had or been told that you have: **Preferred Pharmacy:**

General Eye Conditions	Yes	No	General Health Conditions	Yes	No
Glaucoma			Diabetes		
Cataracts			High Blood Pressure		
Retinal Detachment/Disease			Heart Disease		
Lazy Eye/Amblyopia			Breathing Problems		
Eye Surgery			Auto-Immune Disease		
Dry Eye			Arthritis		
Eye Injury/Infection			Seasonal Allergies		
Other (list):			Other (list):		

Eye History

When was your last eye exam?	Doctors Name/City:	
How old are your present glasses?	Do you wear contacts? Yes No	How old are your contacts?

When do you use glasses/contacts? Constantly Reading Only Distance Only Rarely

11/24/09