PATIENT INFORMATION

Name_____Birth date _____ Date_____ Home Phone _____ Work Phone _____
Street Address_____ City/State_____ Zip Code_____ Other Phone _____
Social Security Number_____ Email Address _____
Occupation/Employer_____ Marital Status _____ ❑ Male ❑ Female ❑ Child
Parent/Guardian info (for patients under 15): Name_____ Relationship_____
Address/Phone (if different from above)_____
Emergency Contact: Name_____Relationship_____ Phone_____

Main reason for todays visit _____
How did Learn about our Practice? ❑ Recommended by _____ ❑Phone Book ❑ Insurance Company ❑ Advertisement
I Interested in or learning more about: ❑ Contact Lenses ❑ Sleeping in Contacts ❑ Colored Contacts
❑ LASIK ❑ ParagonCRT Corneal Reshaping ❑ Other _____

EYE HEALTH HISTORY

Date of last eye exam_____ By Doctor _____ I currently wear ❑ Glasses ❑ Soft CL's ❑ Gas Perm CL's
Age of Current glasses_____ I have had eye surgery for ❑ LASIK ❑ RK ❑ PRK ❑ Cataract ❑ Other _____
Age of Current CL's _____ Brand and Power if Known_____
CL Wearing Schedule_____How often do you sleep in CL's _____
CL Replacement Schedule_____ Cleaning Solution _____

I have been diagnosed with:
❑ Cataracts _____
❑ Glaucoma _____
❑ Lazy Eye (Amblyopia) _____
❑ Retinal tear or Detachment _____
❑ Macular Degeneration_____
❑ Blindness or Loss of Vision _____
❑ Eye Allergies_____
❑ Eye Injury _____
❑ Other _____

I have a family history of: Please indicate parents, Grandparents, Siblings, Child
❑ Cataracts _____
❑ Glaucoma _____
❑ Lazy Eye (Amblyopia) _____
❑ Retinal tear or Detachment _____
❑ Macular Degeneration_____
❑ Blindness or Loss of Vision _____
❑ Other _____

What Eye drops do you use (RX & OTC)_____

MEDICAL HEALTH HISTORY

Primary Care Doctor_____ Office Phone Number _____ Date of Last Evaluation _____

ALL Current Medications_____

Allergies (including drug allergies)_____

Female Patients only: Are you currently Pregnant? ❑ Yes ❑ No ❑ Not Sure Are you currently nursing? ❑ Yes ❑ No

I have been diagnosed with:
❑ Diabetes How Long _____ Typical Blood sugar is _____
❑ Insulin Dependent Medication for _____
_____❑ Vision loss from or Retinopathy since _____
❑ High Blood Pressure Typical Pressure _____ ❑ controlled
❑ Heart Problems_____
❑ Respiratory Problems_____
❑ Brain disease or injury_____
❑ Headaches_____
❑ Cancer_____
❑ Arthritis _____
❑ Gastrointestinal _____
❑ Urogenital or Kidney disease_____
❑ Depression_____
❑ Blood disorders_____
❑ Mental disorders_____
❑ Thyroid Problems_____
❑ Hepatitis or Liver Disease_____
❑ High Cholesterol _____
❑ Tuberculosis _____
❑ Venereal disease_____
❑ Steroid treatment ❑ past ❑ present _____
❑ HIV positive or ❑ AIDS _____
I use ❑ alcohol ❑ tobacco ❑ recreational substances_____
❑ Other _____

I have a family history of: Please indicate Parents, Grandparents, Siblings, Child
❑ Diabetes_____
❑ High blood pressure_____
❑ Heart Problems_____
❑ Respiratory Problems_____
❑ Cancer_____
❑ Other _____