Patient Name_____ Date_____
Parent/Guardian (If applicable)_____
Address_____
Phone (cell)_____ Phone (home)_____ Date of Birth_____
Email_____ SSN_____

Reason for today's visit_____

Ocular History (please list any eye surgeries, diseases or other issues)

_____

Do you wear contact lenses and/or want an exam for contact lenses (extra fee)? ☐ Yes ☐ No

Medical History--Please review and check any conditions in the following body systems.

Constitutional/General
☐Developmental Delay
☐ Cancer

Ear, Nose, Throat
☐Hearing Loss
☐Sinusitis
☐Dry Mouth

Neurological
☐Multiple Sclerosis
☐Epilepsy
☐Dementia
☐Migraine
☐Autism Spectrum

Psychiatric
☐Depression
☐Attention Deficit
☐Anxiety Disorder
☐Bipolar Disorder

Cardiovascular/Heart
☐High Blood Pressure
☐Heart Disease
☐Stroke

Respiratory/Breathing
☐Smoker
☐Asthma
☐Emphysema
☐COPD
☐Sleep Apnea

Gastrointestinal
☐Reflux
☐Crohn's Disease

Genitourinary
☐Kidney Disease
☐Prostate
☐HIV/AIDS
☐STD

Musc/Skeletal
☐Osteoarthritis
☐Fibromyalgia
☐Osteoporosis
☐Gout

Skin/Integ
☐Eczema
☐Rosacea
☐Herpes Zoster or Simplex

Endocrine
☐Thyroid Dysfunction
☐Diabetes T1 T2 Borderline

Blood/Liver
☐Anemia
☐Hepatitis
☐High Cholesterol
☐Leukemia

Allergy/Immunologic
☐Lupus
☐Rheumatoid Arthritis
☐Allergies, environment or drug
☐Sjogren's Syndrome

Other Conditions not listed
_____
_____

Current Medications. Please supply a list to our staff or write them here:

_____

_____

Medication Allergies ☐none_____
Primary Care Physician_____
Pharmacy_____

Family History
☐ Diabetes ☐ High Blood Pressure ☐ Glaucoma ☐ Cataract
☐ Cancer ☐ Macular Degeneration

Do you:
Smoke – if yes, how much per day?_____
Drink alcohol – if yes, how much?_____

Occupation_____ Hobbies_____