

Legal Name: _____ Date of Birth: ____-____-____ Date: ____-____-____
(First) (Middle) (Last) (Nickname)

Address: _____ Apt/Lot _____
(Street) (City) (State) (Zip code)

Home Phone: _____ Work: _____ Cell Phone: _____

Email Address: _____@_____ Social Security #: ____-____-____

Communication Preference (Circle one) Telephone or E-mail. Would you like text notifications /reminders? YES / NO

Preferred Language: _____ Race/Ethnicity: _____ Height: _____ Weight: _____

Do you smoke? _____ If yes, how much? _____ If Former, how long ago did you quit? _____

Marital status _____ Employer: _____ Occupation: _____

Emergency Contact information: Name: _____ Relation _____ Number _____

List all Current medications including prescriptions, Over-the-counter, vitamins, or eye drops:

- I do **NOT** take any Medications
- I will **PRESENT** my medication list (That we could copy)

Are you allergic to any Medications? Yes _____ No _____ If yes, please list: _____

Do you wear contact Lenses? Yes _____ No _____ If yes, what type? _____

Are you interested in contact lenses? Yes _____ No _____

Do you have these on a **regular basis** Have **you** or a **family** member had any of the following?

Without glasses or contacts?

	You	Family (relation to you)
Blurred Vision _____	_____	_____
Floaters in eyes _____	_____	_____
Flashes of light _____	_____	_____
Burning Eyes _____	_____	_____
Itching Eyes _____	_____	_____
Watery Eyes _____	_____	_____
Dry Eye _____	_____	_____
Eye Strain or pain _____	_____	_____
Headaches _____	_____	_____
	Diabetes _____	_____
	High Blood Pressure _____	_____
	Cardiac Trouble _____	_____
	Breathing/Asthma _____	_____
	Cancer _____	_____
	Allergies _____	_____
	Thyroid disorder _____	_____
	Macular Degen _____	_____
	Glaucoma _____	_____
	Lazy/crossed eye _____	_____
	Cataracts _____	_____

Years since last eye exam _____

Last **Eye-** Doctor seen: _____

Primary Care Physician: _____

List any **eye surgery** you have had: _____

Have you turned to the back of this page to finish?