

Patient Name: _____ **Date of Birth:** _____

Date of last eye exam: _____

Name of doctor: _____

Date of last physical: _____

Name of doctor: _____

Please check if you wear:

Glasses Distance Reading

Bifocal/Progressive

Contacts

wear every day

wear occasionally

sleep in lenses

Medications currently taking, including **eye drops:**

Allergies to medications or substances:

Are you experiencing any problems with your **current glasses or contact lenses**? Please explain:

Are you experiencing any problems with your **vision or eyesight**? Please explain:

In case of emergency, please provide a name and phone number of a person we can contact:

Please check if you, or an immediate blood relative, has had any of the following **EYE** problems:

LASIK/PRK Self _____

Blindness Self _____

Cataract Self _____

Glaucoma Self _____

Macular Degen Self _____

Prosthetic Eye Self _____

Retinal Detach Self _____

Eye Injury Self _____

Eye Surgery Self _____

Tumor Self _____

Foreign Body Self _____

Dry Eye Self _____

Lazy Eye Self _____

Crossed Eyes Self _____

Eye Allergies Self _____

_____ Self _____

_____ Self _____

_____ Self _____

Please check if you, or an immediate blood relative, has had any of the following **MEDICAL** problems:

Diabetes Self _____

Cancer Self _____

AIDS/HIV Self _____

Hepatitis Self _____

High Blood Press Self _____

High Cholesterol Self _____

Arthritis Self _____

Allergies Self _____

Heart Disease Self _____

Graves' Disease Self _____

Thyroid Cond Self _____

Stroke Self _____

_____ Self _____

_____ Self _____

_____ Self _____