Name:_____ Today's Date:_____ Phone #:_____

Address:_____ City/State/Zip:_____

Email Address:_____ Date of Birth:_____ Sex M / F

Spouse/Parent or Guardian (if a minor):_____

Primary Care Physician:_____ Specialist:_____

Reason for Today's Visit:_____

Social History

Marital status: single / married / divorced / widowed Occupation:_____

Are you now, or could you be Pregnant? **YES / NO**

Self/ Family History

Have you ever had an eye injury? **YES / NO** Have you had eye surgery? **YES / NO**

Medical Eye Related Disorders

	Self	Family		Self	Family
Amblyopia (lazy eye)	☐	☐	Retinal Detachment	☐	☐
Glaucoma	☐	☐	Dry Eye	☐	☐
Cataracts	☐	☐	Cornea Disorders	☐	☐
Age Related Macular Degeneration	☐	☐	Other	☐	☐
Diabetic Retinopathy	☐	☐	**None Apply**	☐	☐

Medical History *(if yes to the following please explain)*

	Self	Family		Self	Family
Ears, Nose, Throat, Mouth	☐	☐	Skin	☐	☐
Cardiovascular *(hypertension, high cholesterol, heart disease etc.)*	☐	☐	Neurological *(Stroke, seizures*, migraines etc.)	☐	☐
Respiratory	☐	☐	Anxiety, Depression etc	☐	☐
Gastrointestinal	☐	☐	Endocrine *(diabetes, thyroid disease)*	☐	☐
Genital, Kidney, Bladder	☐	☐	Blood/Lymphatic	☐	☐
Muscles, Bones, Joints	☐	☐	**None Apply**	☐	☐

Cancer History Y / N (if yes, please explain):_____

Surgeries:_____

Are you a current or previous smoker **Y / N** Any drug allergies **Y / N** Seasonal allergies **Y / N**

List any current medications/ drug allergies (carry a list, we are happy to make a copy)

_____