Name: _______________________________________ Date of Birth:____/____/___ Date:____/____/_____

Address:____ City:______________________________ Zip:_____________

Phone Number:_____-_____-_____ Email Address:____________________________________@_________________

Are you willing to receive texts from us? Yes/No Are you willing to receive Emails from us? Yes/No

Name of Medical Doctor:______________________ Last Medical Exam___/___/___ Last eye exam___/___/___

INSURANCE:

Insurance Name: ______________________________ Insurance ID#: ___________________________

Insured's Name: ______________________________ Employer: ______________________________

Insured's Date of Birth: ____/____/_____

Medical History:*(Please circle any of the following that you may have/had experienced)*

What brings you in today?____

Medications(list)____

____

Allergic/Immunology: Allergy/Hay Fever Endocrine: Diabetes-Chronic Fatigue-Thyroid Disease

Muscles/Joints/Bones: Joint Pain-Muscle Pain-Rheumatoid Arthritis Integumentary(skin): Cancer-Easy Bruising-Rashes
Lymphatic/Hematologic: Anemia-Bleeding Problems-Breast Cancer Neurological: Headaches-Migraines-Seizures-Strokes
Cardiovascular: Heart Disease-High Blood Pressure-High Cholesterol

Ears, Nose, Mouth, Throat: Dry Throat/Mouth-Chronic Cough-Postnasal Drip-Sinus Congestion-Runny Nose

Eyes:Blurred Vision-Loss of Vision-Distorted Vision-Double Vision-Dryness-Sandy or Gritty Feeling-Redness-

Foreign Body Sensation-Eye Pain or Soreness-Mucous Discharge-Tired Eyes-Itching-Excess Watering/Tears

Styes or chalazion-Burning-Chronic Infection of Eye or Lid-Glare/Light sensitivity-Flashes/Floaters

Are you pregnant or nursing? Yes/No Do you Currently wear glasses? Yes/No

And if so, how long have you had them? ___________________________ Do you have visual difficulty when driving? Yes/No

Do you ever experience? Dryness-Redness-Itching-Burning-Discomfort-Poor Vision

Family History-Please note any family history. Parents, Grandparents, Siblings, Children, Living or Deceased.

Blindness? Yes/No Relationship?________________ Cancer? Yes/No Relationship?____________________

Cataract? Yes/No Relationship?_________________ Diabetes? Yes/No Relationship?___________________

Crossed Eyes? Yes/No Relationship?________________ Heart Disease? Yes/No Relationship?_________________

Glaucoma? Yes/No Relationship?__________________ High Blood Pressure? Yes/No Relationship?________________

Retinal Detachment? Yes/No Relationship?_____________ Lupus? Yes/No Realtionship?______________________

Macular Degeneration? Yes/No Relationship?___________________ Thyroid Disease? Yes/No Relationship____________

____

Contact Lens History: Do You wear Contacts? Yes/No If yes, how old are your contacts______________________

What brand are they?_______________________How many hours a day do you wear your contacts?_______________

How often do you replace your contacts? Daily-Weekly-Monthly-More than one Month

Do you sleep in your contacts? Yes/No

____

Signature: _______________________________________ Date:____________________________