## Patient Information

Last Name | First Name | MI | Gender

Birth Date

Address | Apt | City | State/Zip

Home Phone | Work Phone | Cell Phone

E-mail | What is the best way to reach you?

Occupation/ Employer

Physician's Name | Physician's Phone

## Insurance

Medical Insurance | Vision Insurance

If you on a family member's policy, please provide their full name and date of birth.

## Health Information

**Personal Medical History**

- ADD
- AIDS/ HIV Positive
- Allergies
- Alzheimer's
- Anemia
- Asthma
- Blood Clotting Disorder
- Cancer
- COPD
- Depression
- Diabetes
- Dialysis
- Drug Abuse
- Elevated Cholesterol
- Gout
- Hearing Loss
- Heart Disease
- High Blood Pressure
- Kidney Disease
- Lupus
- Multiple Sclerosis
- Sarcoidosis
- Seizures
- Sickle Cell
- Sleep Apnea
- Stroke
- Thyroid Condition
- Women: Nursing or Pregnant?
- Other

**Personal Eye History**

- Wear Glasses
- Wear Contact Lenses
- LASIK
- Cataracts
- Conjunctivitis
- Corneal Ulcer
- Eye Injury
- Glaucoma
- Iritis or Uveitis
- Ocular Herpes
- Retinal Detachment
- Retinal Tear
- Permanent Vision Loss
- Eye Surgery
- Diabetic Retinopathy
- Retinitis Pigmentosa
- Sjogren's
- Strabismus (eye turn)
- Amblyopia
- Vision Therapy
- Color 'Blindness'
- Other

Your Current Medications

No Current Medications

Drug Allergies

No Known Drug Allergies

Family Eye History

Cataracts

Macular Degeneration

Retinal Detachment

Glaucoma

Retinitis Pigmentosa

Other

## Social History

Are you

Do you drink alcohol?

Do you Smoke Cigarettes?

If current smoker, how many packs per day?

How may years?

List people you authorize to receive medical information on your behalf:

Patient or Guardian's Signature ____________________________________________

Date

Guardians's name and relationship