



Date: _____ Social Security # _____

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Work#: _____

E-mail: _____ Status: Married Single Divorced Widowed

Work Place/School: _____ Occupation/Grade: _____

Emergency Contact (Name/Phone): _____

Primary Language: _____ Race: _____ Ethnicity: _____

How did you hear about our office? _____

Primary Care Doctor: _____ Last exam: _____ Pharmacy: _____

Last Eye Exam: _____ Last Eye Doctor: _____

Do you wear glasses? _____ How often do you wear sunglasses? _____

How old are your glasses? _____ Do you wear Contacts? (Brand/Power) _____

How many hours/day do you use the computer? _____ Do you get strain from computer work? _____

Social History: Tobacco: Type/Frequency? _____ Alcohol: Frequency? _____

Ocular History – please check all that apply

- Cataracts
- Macular Degeneration
- Glaucoma
- Diabetes
- Diabetic Retinopathy
- Dry Eye
- Eye infection, Inflammation, Allergy
- Floaters/Flashes of light
- Iritis or Uveitis
- Retinal Defects or Degenerations
- Other: _____
- None

Vision and Eye Concerns

- Redness
- Burning
- Itching
- Tearing
- Discharge
- Blurred Vision
- Eye Strain
- Eye Pain
- Severe Light Sensitivity
- Headache
- Poor Night Vision
- Night Glare
- Double Vision
- Total Loss of Vision
- Other: _____
- None

Immediate Family History – Please list Father, Mother, Brother, Sister or Children

- Blindness _____
- Lazy Eye _____
- Glaucoma _____
- Macular Degeneration _____
- Cancer _____
- Diabetes _____
- High Blood Pressure _____
- Heart Disease _____
- Thyroid _____
- Other _____