

Patient Information:

Name _____ Birthdate: _____
Home Phone: _____ Cell Phone: _____
Address _____ City _____ Zip _____
SS # _____
Email: _____

To better serve your visual needs, please take a moment to fill out our questionnaire.

Employer _____ Occupation _____
Employer Address _____ Employer Phone () _____
Emergency Contact (name and phone#): _____

Reason for visit: _____

Medical History: Name of your primary Dr. _____

Review of Systems: Do you have any problems with any of the following? (check all that apply)

cancer stomach/GI ear/nose/throat genital/urinary nervous system musculoskeletal
 mental skin cardio blood/lymph respiratory allergies

Explanation of any of the above: _____

List all surgeries you've had: _____

List any prescription or non-prescription medications you take: _____

Are you allergic to any medications? _____

Please note any history of the following eye diseases for only you, your parents, grandparents, or siblings:

<u>Disease</u>	You	Family	Relationship to you/explanation
blindness/vision loss	_____	_____	_____
cataract	_____	_____	_____
glaucoma	_____	_____	_____
macular degeneration	_____	_____	_____
retinal disease	_____	_____	_____
cancer	_____	_____	_____
diabetes	_____	_____	_____
heart disease	_____	_____	_____
hypertension	_____	_____	_____

Social History:

Do you drive? yes / no **Please list any vision difficulties while driving:** _____

Do you use tobacco products? yes / no **Drink alcohol?** yes / no **Use any other substances?** yes / no

How did you first hear about our office? _____