



Last Name _____ First Name _____ MI _____ Today's Date: _____ Birth Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Last Eye Exam: _____ Social Security #: _____ Email Address: _____
Guardian (If Applicable): _____ Employer: _____ Occupation: _____
Do you prefer to receive notification by: [] Phone [] Email Can we send text reminders about your appointment? [] Yes [] No
Are you: [] Minor [] Married [] Divorced [] Widowed [] Single [] Separated
Spouse or parents name: _____ Workplace: _____ If student, school attending: _____
Name of Medical Dr.: _____ Clinic _____ Dr. Phone # _____

Do you have a Flex-benefit account: [] Yes [] No Will this exam be covered by your insurance? [] Yes [] No
How did you hear about our office? [] Google [] Facebook [] Friend/Family _____ [] Other _____

Medical History

Do you have any allergies to medications? [] No [] Yes, please explain: _____
List any medications you take (including oral contraceptives, aspirin, over the counter, vitamins, and home remedies): _____

List all major injuries, surgeries, and/or hospitalizations you have had: _____
Have you had your pneumonia vaccination [] Yes [] No Do you have a living will or advanced directive? [] Yes [] No
Check any of the following you have had: [] Crossed Eyes [] Lazy Eye [] Drooping Eyelid [] Prominent Eyes [] Glaucoma
[] Retinal Disease [] Cataracts [] Eye Infections [] Eye Injuries _____
Are you pregnant or nursing? [] Yes [] No Have you had any eye surgeries? [] Yes [] No
Do you wear glasses? [] Yes [] No If yes, how old is your present pair of lenses? _____
Do you wear contact lenses? [] Yes [] No If yes, how old is your present pair of lenses? _____
Type of contact lenses: [] Rigid [] Soft [] Extended Wear [] Other _____ Are they comfortable? [] Yes [] No

Family History

Please note any family history (parents, grandparents, siblings, children; living or deceased) for the following conditions:
(Check all that apply):

Table with 4 columns: DISEASE/CONDITION, NO, YES, ?, and RELATIONSHIP TO YOU. Rows include Blindness, Cataract, Crossed eyes, Glaucoma, Macular Degeneration, Retinal Detachment/Disease, Arthritis, Cancer, Diabetes, Heart Disease, High Blood Pressure, Kidney Disease, Thyroid Disease, and Other.



Social History

This information is kept strictly confidential. However, you may discuss this portion with the doctor if you prefer

Yes, I would prefer to discuss my Social History information directly with my doctor.

Do you drive? Yes No If yes, do you have visual difficulty when driving? Yes No If yes, describe

Do you use tobacco products? Yes No If yes, type/amount/how long: _____

Do you drink alcohol? Yes No If yes, type/amount/how long: _____

Do you use illegal drugs? Yes No If yes, type/amount/how long: _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Review of Systems

Do you currently, or have you ever had any problems in the following areas:

SYSTEM	NO	YES	?	SYSTEM	NO	YES	?
Constitutional				Ears, Nose, Mouth, Throat			
Fever, Weight Loss/Gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integumentary (Skin)				Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Post-Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eyes				Dry Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Distorted Vision/Halos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Side Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular/Cardiovascular			
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mucous Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sandy or Gritty Feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			
Burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Excess Tearing/Watering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitourinary			
Glare/Light Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Genitals/Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Pain or Soreness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bones/Joints/Muscles			
Chronic Infection, Eye/Lid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sties or Chalazion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flashes/Floaters in Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tired Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic / Hematologic			
Endocrine				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid/Other Glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Allergic / Immunologic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain: _____

Doctor's Signature _____ Date _____