Patient Demographics & Medical History

NAME: _____ **Today's Date:**_____

Address: _____

_____

HOME PHONE #: _____ WORK/CELL#: _____

D.O.B.: _____ **SSN #:** _____

Last Eye Exam: _____ **INSURANCE:** _____

RP Name/DOB/SSN: _____

PCP: _____ **PCP phone #:** _____

Any Known Drug Allergies: _____

List any medications you are taking: _____

_____

_____

Do you experience symptoms of nausea while reading in a moving car? Y/N
Are you pregnant and/or nursing? Y/N
Do you wear glasses? Y/N Age of glasses_____
Do you currently wear contact lenses? Y/N Type? ☐Rigid ☐Soft ☐Wear Over-Night

Family History

Please note any family history (parents, grandparents, siblings and/or children, living or deceased) for the following medical conditions:

		Relationship to you
Blindness	Y/N	_____
Cataract	Y/N	_____
Crossed Eyes	Y/N	_____
Glaucoma	Y/N	_____
Macular Degeneration	Y/N	_____
Retinal Detachment/Disease	Y/N	_____
Arthritis	Y/N	_____
Cancer	Y/N	_____
Diabetes	Y/N	_____
Heart Disease	Y/N	_____
High Blood Pressure	Y/N	_____
Kidney Disease	Y/N	_____
Lupus	Y/N	_____
Thyroid Disease	Y/N	_____

Other: _____

PLEASE COMPLETE BACK SIDE