Welcome Back to Our Office

Name: ______________________ Date of Birth: ______________________

Address: ______________________ Employer: ______________________

City: ______________ Zip Code: ________ Occupation: ______________________

Phone Number: ______________________ Spouse: ______________________

Daytime Phone #: ______________________ Email: ______________________

Cell Phone #: ______________________ Do you currently wear contacts? Yes or No

Do you accept text messages? Yes or No If yes, what kind? ______________________

Who is your Primary Care Physician? ______________________

What is the primary reason for your visit today? ______________________

Medications: ______________________

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Allergies to Medications: ______________________

Pregnant or Nursing: Yes or No Height: ____________ Weight: ____________

Tobacco Use: Yes or No Current or Past If yes, how much? ____________

Please list any previous eye surgeries: ______________________

Please list if <u>you</u> or a <u>relative</u> have ever been diagnosed or treated for the following:

Ocular History	Relationship	Medical History	Relationship
Cataracts	____________	Allergies	____________
Corneal Problems	____________	Asthma	____________
Diabetes	____________	Cancer	____________
Dry Eyes	____________	Cholesterol	____________
Eye Injuries	____________	Migraines	____________
Flashes of Light	____________	High Blood Pressure	____________
Glaucoma	____________	Lupus	____________
Macular Degeneration	____________	Stroke/TIA	____________
Ocular Allergies	____________	Hepatitis A B C (circle one)	____________
Double Vision	____________	Kidney Problems	____________
Cross/Eye turn	____________	Multiple Sclerosis	____________
Floaters	____________	Tuberculosis	____________
Retinal Issues	____________	Thyroid	____________
Other	____________	Other	____________

Signature of Patient or Guardian: ______________________ Date ____________