PATIENT INFORMATION Date _____

Last Name _____ First Name_____
Name by which we should call you

_____
Address

_____
City _____ State _____ Zip _____
Date of birth _____ Age _____ Male/Female SS# _____
The best number to reach you: Daytime: _____ Evening _____
Mobile phone _____ email _____

Emergency contact _____ phone _____
Whom may we thank for referring you to us? _____
Reason for appointment? _____
Pharmacy preference (include location) _____
Primary Care Physician _____ Phone _____
Employer _____ Occupation _____
If this is a workman's compensation claim who is the person to contact at your employer's office?

_____
Employer's Address _____
Employer's phone _____ Date of Accident _____

Current Medications
Are you taking ANY kind of medication now? _ Yes _ No (This includes eye drops, prescription medications, BOTOX, over-the-counter or herbal medications).

Name of Medication	How Often Taken ?

Allergies
Are you allergic to any medications? _ Yes _ No (If yes, please list below)

Name of Medication	Type of reaction

Non- medication allergies

Do you have hay fever or food allergies? _ Yes _ No (If yes, please list below)

Name of Allergen	Type of reaction

Patient name

Ocular History
Do you currently have or have you ever had any of the following problems?

	No	In the past	Now
Eye injury			
Eye pain			
Light Sensitivity			
Excess Tearing			
Red Eyes			
Dry Eyes			
Itchy eyes			
Eye infections			
Blurred Vision			
Cataracts			
Glare			
Double Vision			
Fluctuating Vision			
Loss of side vision			
Droopy Lids			
Macular Degeneration			
Glaucoma			
Keratoconous			
Corneal Disease			
Crossed/Lazy Eye			
Eye surgery			
Contacts			
Other			

Health History
Do you currently have or have you ever had any of the following problems?

	No	In the past	Now
Anemia			
Anxiety			
Arthritis			
Cancer			
Depression			
Diabetes			
Dry Mouth			
Emphysema			
Headache			
Heart Disease			
Hepatitis			
HIV			
High Cholesterol			
High Blood Pressure			
Lupus			
Multiple Sclerosis			
Pregnancy			
Sjogrens Disease			
Skin Cancer			
Stroke			
Thyroid Disease			
Unintentional Weight Loss			
Other			

Family History

	Mother	Father	Sister	Brother
Cancer				
Cataracts				
Glaucoma				
Heart Disease				
High Blood Pressure				
Macular Degeneration				

Social History	No	Yes	How much?	How often?
Do you smoke?				
Do you drink alcohol?				
Recreational drugs?				

What is the main reason you are seeing the doctor today?