Patient Name: ______________________________ **Date of Birth:** ______________ **SS#:**______________________

Referring Doctor: ___________________ **Family Physician:** ___________________ **Pharmacy:** ________________

E-mail Address: ____ **Race:** _____________________________

Emergency Contact: ___________________________________ **Emergency Phone:** ___________________________

Medications: Attach a list of current medications or list them below. Include over the counter and prescription medications

Name of Medication	Purpose for Medication	Dosage	Frequency

Allergies & Reactions:

Previous Surgeries:

Previous Eye Surgeries:

Family History:

Relationship:
F- Father, M-Mother,
S-Sibling, GP-Grandparent

Y	N	Cancer	________
Y	N	Cataracts	________
Y	N	Diabetes	________
Y	N	Glaucoma	________
Y	N	Macular Degeneration	________
Y	N	High Cholesterol	________
Y	N	High Blood Pressure	________

Social History: Circle all that apply

Use of Tobacco:	Current	Former	Never
Alcohol:	None	Occasional	Heavy
Drugs:	Yes	No	
Occupation:			

List Current Medical Conditions on the back

Central Vision Eyecare

Current Medical Conditions

Condition	
Fever	Yes / No
Headaches	Yes / No
Dementia	Yes / No
Alzheimer's	Yes / No
Sjogrens	Yes / No
Rosacea	Yes / No
Psoriasis	Yes / No
Eczema	Yes / No
Hearing Loss	Yes / No
Wear Hearing Aids	Yes / No
Tinnitius/ ringing in ears	Yes / No
Dizziness or Spinning Sensation	Yes / No
Asthma	Yes / No
COPD	Yes / No
Seasonal Allergies	Yes / No
High Blood Pressure	Yes / No
High Cholesterol	Yes / No
A-Fib	Yes / No
Heart Disease	Yes / No
GERD	Yes / No
Acid Reflux	Yes / No
Crohn's	Yes / No
IBS	Yes / No
Prostate Problems	Yes / No
Overactive Bladder	Yes / No
Currently Pregnant	Yes / No

Condition	
Arthritis	Yes / No
Osteoarthritis	Yes / No
Fibromyalgia	Yes / No
Multiple Sclerosis	Yes / No
Gout	Yes / No
History of Bell's Palsy	Yes / No
Stroke	Yes / No
Migraines	Yes / No
Seizures	Yes / No
Parkinson's	Yes / No
Thyroid Diease	Yes / No
Diabetic	Yes / No
Type _____ Last A1C _____	Yes / No
Cushing's	Yes / No
Depression or Anxiety	Yes / No
Bi Polar or Schizophrenia	Yes / No
ADD or ADHD	Yes / No
Anemia	Yes / No
Sarcoidosis	Yes / No
Lupus	Yes / No
Lyme's	Yes / No
HIV / Aids / Hepatits	Yes / No
Shingles / Herpes	Yes / No
Cataracts	Yes / No
Glaucoma	Yes / No
Macular Degeneration	Yes / No

Please list any other Systemic Illnesses: ____

____

____

Last Eye Exam: ________________________ **Do you wear glasses?** (circle) Yes / No

Do you wear contacts? (circle) Yes / No

Brand: ________________________________ ☐ Monthly ☐ Daily ☐ RGP

Current Glasses RX:

Right Eye: ____________________________________ **Left Eye**: ____________________________________

Signature: ____ **Date:** ____________________