PATIENT INFORMATION FORM

NAME____**DATE**____/_____/_______**DATE OF BIRTH**____/_____/______**AGE**_______

OCCUPATION________________________**NAME OF HEALTH/VISION INSURANCE**___________________________________

Do you smoke cigarettes? YES / NO **Do you drink alcohol? YES / NO** **Do you use illegal drugs? YES / NO**

When was your last eye exam? ____________________

Do you wear eyeglasses? YES / NO (CIRCLE) If YES, do you wear them for: ☐**Distance,** ☐**Near,** ☐**Both,** ☐**Never Wear (CHECK ONE)**

Do you wear contact lenses? 1) YES / NO (CIRCLE) 1) If so, how often do you dispose of each pair: ☐**daily,** ☐**2 weeks,** ☐**monthly,** ☐**2 months,** ☐**longer than 2 months**

2) Brand of contact lenses: ____

3) How many hours per day do you wear contacts? _______________

Have you ever had any of the following conditions? Check all that apply or ☐**NONE**

- ☐**Lazy Eye**
- ☐**Crossed Eye**
- ☐**Eye Injury**
- ☐ **Dry Eyes**
- ☐**Eye Infection**
- ☐**Cataracts**
- ☐**Glaucoma**
- ☐**Styes**
- ☐**Eye Surgery**
- ☐**Laser Vision Correction**
- ☐**Retinal Disease**
- ☐**Red, Irritated Eyes**
- ☐**Other (Please give details)**____

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Do you take any medications? If YES please list or check box if ☐**NONE**

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Do you have any allergies (including allergies to medications): YES / NO (CIRCLE) If yes, please list:___________________________________

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Have you ever had any of the following medical problems? Check all that apply or ☐**NONE**

- ☐**Diabetes**
- ☐**Stroke**
- ☐**Migraine Headaches**
- ☐**Cancer/Tumors**
- ☐**High Blood Pressure**
- ☐**Thyroid Disorder**
- ☐**Multiple Sclerosis**
- ☐**High Cholesterol**
- ☐**Heart Disease**
- ☐**Arthritis (Osteo or Rheumatoid)**
- ☐**Rosacea**
- ☐**Fainting**
- ☐**Other**____

Please give details of any family members (siblings, parents, children, grandparents) that have had an eye disease:

☐**NONE**

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Please indicate any family history of diseases such as diabetes, high blood pressure, heart, thyroid, or other problems:

☐**NONE**

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Reviewed by ____ ☐ **NO changes** **Date**___________________

Reviewed by ____ ☐ **NO changes** **Date**___________________

Reviewed by ____ ☐ **NO changes** **Date**___________________

Reviewed by ____ ☐ **NO changes** **Date**___________________