Patient Full Name____ Date of Birth________________________

Gender _____ Race/Ethnicity ________ Date of last eye exam (new patients only): ____________________

Occupation: ___________________________ Hobbies: ____

Height: _____________ Weight: ____________

Preferred pharmacy (please include location): ____

Prescription Medications (including eye drops): ____

____

Over the counter medications/supplements (including eye drops): ____

____

Medication Allergies: ____

Other allergies: ____

Previous eye injuries/surgeries: ____

Medical history (please mark all applicable):

	Diabetes		Autoimmune
	Thyroid disease		Neurological
	Hypertension		Psychological
	Cardiovascular		Migraine
	Cancer		History of blood transfusion
	Kidney disease		Currently pregnant/nursing
	Asthma/COPD/Other respiratory		Other

Additonal information on any marked above: ____

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Family history:

	Glaucoma		Diabetes
	Macular Degeneration		Cancer
	Retinal detachment		

Tobacco use (circle): None Cigarettes Smokeless tobacco Vape Packs/per day: _____ Years smoked: _____

Alcohol use (circle): Yes No Average drinks/day (circle one): Less than 1 1-2 3 or more

Current eye symptoms:

	Blurred vision		Burning
	Dryness		Redness
	Itching		Pain
	Swollen eyelids		Double vision
	Fatigue/discomfort on computer		Foreign body sensation (feels like something in eye)
	Glare at night		Contact lens discomfort or awareness

Contact lens wearer (circle one): Yes No Brand/type (new patients only): ______________________________

Interested in trying contact lenses if not currently wearing (circle one): Yes No

Interested in refractive surgery/LASIK (circle one): Yes No

OFFICE USE ONLY

Reviewed: ____________________________________ Date:____________________