Last Name_____First Name_____ MI_____

Address _____City_____State____Zip_____

Telephone (H)_____(C)_____(W)_____

Date of Birth_____SSN_____Email Address_____

Race (CIRCLE: American Indian, Asian, African American, Hispanic, Pacific Islander, White)

Marriage Status (CIRCLE: Single, Married, Divorced, Widow)

Employment Status (CIRCLE: Student, Part-time, Full-time, Self, Retired)

Occupation _____Employer_____

Emergency Contact and Telephone_____

Date of Last Eye Exam_____ Today's Date_____

MEDICAL INFORMATION

Allergies Y/N_____

Medication Allergies Y/N _____

Medication(s)_____

Have you had any operations? Y/N (Include Dates)_____

Do you use cigarettes/tobacco? Y/N Alcohol? Y/N What is your height?_____ Weight?_____

Do you have any health conditions? *(PLEASE CIRCLE ALL THAT APPLY)*

ADD/ADHD	Hypertension	Sickle Cell Anemia	Pregnant
Anxiety	Heart Disorder	Thyroid Disorder	
Asthma	Gout	Cancer (Type)_____	
Arthritis	Kidney Disorder	Diabetes (Oral, Insulin, Diet) (Date)_____	
Cholesterol	Lupus	Stroke (Date)_____	
COPD	Multiple Sclerosis	Other _____	

Primary Care Physician Name_____Location_____

Phone_____Fax _____Date of Last Visit_____

Pharmacy_____Location_____Phone_____

FAMILY HISTORY

Glaucoma Y/N Relation_____ Macular degeneration Y/N Relation _____

Cataracts Y/N Relation_____ Retinal detachment Y/N Relation _____

Other eye condition(s) Y/N List:_____Relation _____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y/N Type_____

Eye injuries? Y/N Type_____

Do you have Glaucoma? Y/N Cataracts? Y/N Blurred Vision? Y/N Dry Eyes? Y/N

Headaches/Migraines? Y/N Other Eye Problems?_____

Do you wear glasses? Y/N Readers? Y/N Contacts? Y/N Type_____

Additional information_____

Whom may we thank for referring you? _____

Doctor's initials_____

QUESTIONNAIRE