NAME:_____AGE:_____D.O.B._____

EMAIL ADDRESS:_____

Height:_____ Weight:_____ Tobacco: YES: ____ NO: ____Alcohol: YES:____NO:_____

Occupation: Retired _____

Primary Care or Referring Physician:_____

Reason for visit:_____

Have you had any hospitalizations or surgeries in the past 3 years: If so, please list when and why:_____

_____

Please list any medications you are taking (Prescription and Over the counter) (Skip if you have a list with you)

Medications	Reason	Medications	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any medication allergies: No known allergies or:_____

_____

List any eye injuries or surgeries:_____

_____

List any eye medication you are currently using (including over the counter):_____

_____

Do you or immediate family have any of the following eye problems: UNKNOWN FAMILY HISTORY

CATARACTS: Self Mother Father Brother Sister Grandparents

GLAUCOMA: Self Mother Father Brother Sister Grandparents

MACULAR DEGENERATION: Self Mother Father Brother Sister Grandparents

If you are here for a comprehensive eye exam and would like to be checked to see if you need a change in your glasses prescription or want to see if you need glasses, there may be a fee of $45.00 that most insurance will not cover. You will be asked to pay this at time of visit. Do you want to be checked today: YES:_____NO:_____