PATIENT FORM

Primary Doctor :___________________________________

Phone #/ Fax:___________________________________

Pharmacy Name:________________________________

Phone # Fax#:__________________________________

PATIENT NAME:

Date of Last Eye Exam

Currently Wear Glasses?

Currently Wear Contacts?

Reason for Today's Visit

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

Cataracts	*yes*	*no*	*family*
Crossed Eye	*yes*	*no*	*family*
Glaucoma	*yes*	*no*	*family*
LASIK or RK	*yes*	*no*	*family*
Lazy Eye	*yes*	*no*	*family*
Macular Degeneration	*yes*	*no*	*family*
Retinal Detachment	*yes*	*no*	*family*

Are you currently experiencing, or have experienced, any of the following? Check all that apply.

- ☐ Blurry Vision *near or distance*
- ☐ Burning
- ☐ Discharge
- ☐ Double Vision
- ☐ Dryness
- ☐ Excess Tearing/Watering
- ☐ Eye Infection
- ☐ Eye Pain or Soreness
- ☐ Floaters or Spots
- ☐ Halos
- ☐ Headaches
- ☐ Itching
- ☐ Light Flashes
- ☐ Light Sensitivity
- ☐ Redness
- ☐ Sandy or Gritty Feeling

MEDICAL HISTORY

Have you or a family member experienced, or been treated for, any of the following? Circle all that apply.

AIDS/HIV	*yes*	*no*	*family*
Allergies	*yes*	*no*	*family*
Arthritis	*yes*	*no*	*family*
Asthma	*yes*	*no*	*family*
Blood/Lymph Disorder	*yes*	*no*	*family*
Cancer	*yes*	*no*	*family*
Diabetes	*yes*	*no*	*family*
Ears, Nose, Throat Conditions	*yes*	*no*	*family*
Gastrointestinal Conditions	*yes*	*no*	*family*
Heart Disease	*yes*	*no*	*family*
High Blood Pressure	*yes*	*no*	*family*
High Cholesterol	*yes*	*no*	*family*
Kidney Disease	*yes*	*no*	*family*
Lupus	*yes*	*no*	*family*
Neurological Conditions	*yes*	*no*	*family*
Psychiatric Disorder	*yes*	*no*	*family*
Seizures	*yes*	*no*	*family*
Skin Conditions	*yes*	*no*	*family*
Stroke	*yes*	*no*	*family*
Thyroid Dysfunction	*yes*	*no*	*family*

Current Medications
(prescription and over-the-counter and dosage)

Medication Drug Allergies

Height **Weight**

Are you pregnant or nursing?

Do you smoke?

Have you ever smoked?

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