

Patient Name _____

Patient D.O.B. _____

Address: _____

Occupation _____

Is there a family history of:

Home Phone: _____/Work Phone _____

Diabetes Y N

Cell Phone: _____/Email _____

High blood pressure Y N

Preferred Method of Contact _____

Glaucoma Y N

Lazy eye Y N

Macular degeneration Y N

Insured's Name: _____ Insured's D.O.B _____

Have you ever had any:

Relationship to Insured: self spouse child other

Cataracts Y N

Glaucoma Y N

Primary Physician's name _____
(Medical Doctor)

Eye surgery Y N

-if yes, what type? which eye (R, L)?

Physical health: (Circle one)
Excellent Good Fair Poor

Cataract R L

Glaucoma R L

Eye muscle R L

Do you smoke? Y N

Retina R L

Do you drink alcoholic beverages? Y N

Lid R L

Refractive (PRK, LASIK) R L

For women:

Are you pregnant? Y N

Are you nursing? Y N

List any medications you are taking:

(If none, please write "none")

Have you ever had any of the following conditions?

Diabetes Y N

High blood pressure Y N

High cholesterol Y N

Heart problem Y N

Thyroid disorder Y N

Asthma/breathing problem Y N

Sinus problems Y N

Migraine headaches Y N

Cancer/blood disorder Y N

Digestive/stomach problems Y N

List any medications you are allergic to:

List any other medical conditions you have had:
(eg. Arthritis)

Signature

Date

Drs. initials _____