Patient Name_____

Address:_____

_____

Home Phone:_____/Work Phone_____

Cell Phone:_____/Email_____

Emergency Contact
and Phone # _____

Insured's Name:_____Insured's D.O.B_____

Relationship to Insured: self spouse child other

Primary Physician's name_____
(Medical Doctor)

Physical health: (Circle one)
Excellent Good Fair Poor

Do you smoke?	Y	N
Do you drink alcoholic beverages?	Y	N

For women:

Are you pregnant?	Y	N
Are you nursing?	Y	N

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

_____

_____

_____

Patient D.O.B._____

Occupation _____

Is there a family history of:

Diabetes	Y	N
High blood pressure	Y	N
Glaucoma	Y	N
Lazy eye	Y	N
Macular degeneration	Y	N

Have you ever had any:

Cataracts	Y	N
Glaucoma	Y	N
Eye surgery	Y	N
-if yes, what type? which eye (R, L)?		
Cataract	R	L
Glaucoma	R	L
Eye muscle	R	L
Retina	R	L
Lid	R	L
Refractive (PRK, LASIK)	R	L

List any medications you are taking:
(If none, please write "none")

_____

_____

_____

_____

_____

List any medications you are allergic to:

_____

_____

Signature Date

Drs. initials _____