Patient Name: _____ Today's Date: _____

Parent Name (for minors): _____ Birth Date: _____

Address: _____ Phone: _____

email: _____@_____.____

☐ I consent to the use of electronic communication (text or email) for appointment reminders, recalls and other notices. By not checking this box, I agree to not receive recall notices when I am due for my next appointment(s).

What is the main reason for your visit today (ex: routine vision exam, dry eyes, itching, blurry vision): _____

_____

Do you have any drug, seasonal, or environmental allergies? ☐ YES OR ☐ NO If yes, please list them:

_____

Have you ever had an eye infection, injury or surgery? ☐ YES OR ☐ NO If yes, please describe:

_____

Do you experience flashes of Light? ☐ YES OR ☐ NO If yes, please describe when:

_____

Have you ever been a smoker? ☐ YES ☐ No *If yes, what is your smoking status? ☐ Current Smoker ☐Former Smoker

Have **YOU** been diagnosed with any of the following: **(Check all that apply)**

- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Fibromyalgia
- ☐ Muscular Dystrophy
- ☐ Osteoarthritis
- ☐ Ankylosing spondylitis
- ☐ Heart Disease
- ☐ Hypertension
- ☐ Stroke
- ☐ Vascular Disease
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Ulcers
- ☐ Digestive Problems
- ☐ Acid Reflux
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ Migraines
- ☐ Developmental Disability
- ☐ STD, viral herpetic, chlamydia
- ☐ Depression
- ☐ Panic Disorder
- ☐ Schizophrenia
- ☐ Anxiety
- ☐ Anemia
- ☐ Leukemia
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Diabetes
- ☐ Thyroid Dysfunction
- ☐ Hormonal Dysfunction
- ☐ Eczema
- ☐ Rosacea
- ☐ Psoriasis
- ☐ Skin Cancer
- ☐ Other (please describe)

Have you or any blood relatives been diagnosed with the following (**Circle Yes or No**): _____

Self		**Condition**	**Blood Relatives**		**Relation to you (Example: Mother, Sibling, Grandmother, etc)**
YES	NO	Cataracts	YES	NO	
YES	NO	Retinitis Pigmentosa	YES	NO	
YES	NO	Retinal Detachment	YES	NO	
YES	NO	Blindness	YES	NO	
YES	NO	Colorblindness	YES	NO	
YES	NO	Glaucoma	YES	NO	
YES	NO	Macular Degeneration	YES	NO	

Do you take any medications (including Multivitamins, Aspirin, Vitamins, Birth Control, etc)? ☐ YES OR ☐ NO

If yes, please list them or provide a list:

_____

Vision Insurance Company: _____

Medical Insurance Company: _____