DIAMOND VISION OPTOMETRY, INC.

Date _____

NAME Mr/Mrs/Ms _____ Date of Birth _____ Age _____
(first) (last)
Guardian (if applicable) _____ Occupation _____

Address _____ City _____ State ____ Zip _____

Phone _____ Work _____ Cell _____

Email _____ Ethnicity _____

Emergency Contact _____ Phone _____

Last Eye Exam _____ Last Medical Exam _____

Name of Medical Doctor _____ Phone _____

Medical Insurance _____

Primary Subscriber _____ SS# _____ Birthdate _____ Relationship _____

Vision Insurance _____

Primary Subscriber _____ SS# _____ Birthdate _____ Relationship _____

PATIENT'S OCULAR/ MEDICAL HISTORY

Do you have any allergies to medications? ____Yes ____No If yes, please list _____

List all the medications you take _____

List all the major injuries, surgeries, and /or hospitalization you have had _____

Are you pregnant and/or nursing? ____Yes ____No

Do you wear glasses? ____Yes ____No If yes, how old is your current pair of glasses? _____

Type of glasses _____ What do you like about your glasses? _____

Do you wear contact lenses? ____Yes ____No If yes, how old is your current pair of lenses? _____

Type of contact lenses _____ What do you like about your contacts? _____

Please check any conditions that you have or have had in the past:

- ☐Blurred Vision
- ☐Loss of Vision
- ☐Double Vision
- ☐Crossed/Lazy Eyes
- ☐Flashes/Floaters
- ☐Eye Surgery
- ☐Cataract
- ☐Retinal Detachment
- ☐Macular Degeneration
- ☐Glaucoma
- ☐Pain
- ☐Excessive Tearing
- ☐Dryness
- ☐Itching/Burning
- ☐Eye Infection/Redness
- ☐Eye Injuries
- ☐Diabetes
- ☐High Blood Pressure
- ☐High Cholesterol
- ☐Heart Disease
- ☐Headache
- ☐Migraine
- ☐Stroke
- ☐Thyroid
- ☐Arthritis
- ☐Thyroid Disease
- ☐Lupus
- ☐Cancer
- ☐Asthma
- ☐Lung Disease
- ☐Other _____

SOCIAL HISTORY

This and all other information is kept strictly confidential. However, you may discuss this portion directly with the doctor if you prefer.

Do you drive? ____YES ____NO If you have visual difficulty when driving, describe _____

Do you use tobacco products? ____YES ____NO (If yes) type/ amount/ how long: _____

Do you drink alcohol? ____YES ____NO (If yes) type/ amount/ how long: _____

Do you use recreational drugs? ____YES ____NO (If yes) type/ amount/ how long: _____

Have you ever been exposed to or infected with: ____Gonorrhea ____ Hepatitis ____HIV ____Syphilis