PATIENT INFORMATION

First Name _____ M_____ Last Name _____

SSN_____-_____-_____ Date of Birth_____ Age_____ Gender_____

Address_____City_____State_____Zip_____

Telephone (Mobile)_____ (Home)_____

Email _____ Married? Y / N

Emergency Contact/Relation_____ Tel#_____

Primary Insurance_____ ID# _____ Group#_____

Secondary Insurance_____ ID# _____ Group#_____

MEDICAL HISTORY

Name of Family Doctor: _____ Date of Last Visit_____

Do you have problems with any of the following systems? *(please circle all that apply)*

Diabetes/Thyroid	Y / N	Neurologic	Y / N	Psychiatric	Y / N
Ear/Nose/Sinus	Y / N	Genitourinary	Y / N	Gastrointestinal	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/Lymph	Y / N
Asthma/COPD	Y / N	Skin	Y / N	Immune System	Y / N

If yes, please explain? _____

_____

Medications: _____

_____

Allergies: _____ What happens? _____

VISION HISTORY

Do you currently wear glasses? Y / N Contact Lenses? Y / N

Are you interested in Laser Vision Correction? _____

Reason for today's visit? _____

Past Eye Problems_____

Previous Eye Surgery_____ Current Eye Drops_____

_____ _____

Does anyone in your family suffer from the following:

Cataracts? Y/N Relation_____ Macular Degeneration? Y/N Relation_____

Glaucoma? Y/N Relation_____ Retinal Detachment? Y/N Relation_____

Diabetes? Y/N Relation_____ High Blood Pressure? Y/N Relation_____

Other Conditions? _____

Is anyone in your family blind? Y/N From what? _____

Who may we thank for referring you? _____

Doctor's Initials_____