

Name: _____

Date: _____

Please Provide the following:

Height: _____ Weight: _____

Please List Any Medications You are Taking (You may supply a separate list if needed)

- 1.
- 2.
- 3.
- 4.

Please list Drug Allergies

Primary Care Physician:

Are you Pregnant? Yes No

Are you Nursing? Yes No

Do you have problems with any of the following (please circle):

Diabetes	Yes	No	Musculoskeletal	Yes	No
Ear/Nose/Throat/Sinus	Yes	No	Respiratory	Yes	No
Digestive System	Yes	No	Genitourinary	Yes	No
Blood Lymph System	Yes	No	Immunologic	Yes	No
Endocrine (i.e. Thyroid)	Yes	No	Do you smoke?	Yes	No
Central/Nervous System	Yes	No	Do you drink alcohol?	Yes	No
Mental/Emotional State	Yes	No			
Cardiovascular (Heart)	Yes	No			

Do you (please circle):

Wear Contact Lenses	Yes	No	Please be aware that a contact lens evaluation is not part of a regular exam and has an additional fee that may not be covered by insurance _____(please initial)
If no...are you interested?*	Yes	No	
See Flashing Lights	Yes	No	
Have Dry, Gritty Eyes	Yes	No	
Watery Eyes	Yes	No	

Do you have problems with night driving and/or glare? Yes No

Work on a Computer? Yes No If yes how many hours per day? _____

Have you had cataract surgery? Yes No

If yes...Date: (R) _____ (L) _____

Doctor: _____

Other Surgery (Please List with dates)

Return visit Reviews:

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____