Personal Information

Last Name:_____First Name:_____

DOB: ___/____/____ Gender: M/F

If a minor, name of parent or guardian:_____DOB:__/__/____

Address:_____City:_____State:_____

Zip:____Home(_____)_____Cell:(____)_____Email:_____

Employer:_____Occupation:_____

Personal History

What is the reason for today's exam_____

Do you wear contact lenses? _____ Date of last eye exam: _____

Previous eye conditions: dry eye cataracts glaucoma retinal disease macular degeneration strabismus iritis/ uveitis floaters flashes of light double vision previous eye injuries previous eye surgeries:_____

MEDICATIONS: _____

_____

_____

_____ _____

Any know allergies, medications or other_____

Personal Medical History: Circle all that apply:

Ear/ Nose/ Throat: hearing loss dry mouth vertigo sinus conditions

Neurological: multiple sclerosis epilepsy stroke migraines autistic cerebral palsy

Psychiatric: depression anxiety ADHD bipolar

Cardiovascular: hypertension heart disease congestive heart failure

Respiratory: emphysema COPD sleep apnea asthma

GI: chrons colitis ulcer acid reflux celiac disease

GU: kidney disease prostate disease STD pregnant nursing

Muscular/Skeleton: arthritis fibromyalgia muscular dystrophy osteoarthritis ankylosing spondylitis osteoporosis

Integumentary: eczema rosacea psoriasis shingles

Endocrine: thyroid dysfunction diabetes

Hematologic/ Lymph: cholesterol anemia

Allergies/ Immune: seasonal lupus sjogren's syndrome

Other conditions:

_____

_____

Family History:

Eye history: glaucoma macular degeneration retinal disease keratoconus corneal disorder

other:_____

Health History: Diabetes Cancer Hypertension Thyroid disease Heart disease Other:_____

Social History: Do you smoke or have you ever smoked?_____ Do you drink alcohol?_____