Today's Date_____

Welcome to All About Eyes!

Name (Last, First, MI)_____Nickname_____
Date of Birth _____ Marital status:_____Sex: □M □F
Address _____ City_____ State ____ Zip Code _____
Preferred phone number _____ E-mail address _____
Occupation_____Employer_____
Hobbies/Sports_____
Emergency contact name_____ Phone #_____
If a dependant: Mom's name _____Dad's name:_____

Health History

Please check any/all **health conditions** that apply to you:

□Diabetes □High Blood pressure □Elevated cholesterol □Cancer (type:_____)
□ Thyroid disorder □Stroke □Heart disease □Arthritis □Other: _____
Women only: □Pregnant (____ weeks) □Nursing
Do you use tobacco? □No □Yes (How much?_____) Do you use recreational drugs? □No □Yes
Please list any/all **surgeries or operations**: _____
Please list all **current medications**: _____
_____
Do you have any **medication allergies**? □No □Yes, please list:_____
Do you have any other **allergies**? □No Yes, please list:_____
Any other health problems we should know about?_____

Ocular History

When was your last **eye exam**? _____
Do you wear: □ Glasses □ Contact lenses (type:_____)
Are you interested in corrective vision surgery? □Yes □No
Please check any/all of the following **ocular symptoms** that you experience:

□Blurred vision	□Eye strain	□Headaches	□Double vision
□ Dry eyes	□Itchy eyes	□Watery eyes	□Redness
□Floaters	□Flashes of light	□Loss of vision	□Distorted vision
□Problems with glare	□Sensitivity to light	□Halos	

Please check any/all of the following **eye conditions** that apply to you:
□Glaucoma □Cataracts □Macular degeneration □Eye turn/lazy eye □Other: _____

Family History

Please check any/all conditions that apply to your **family members**:

□Glaucoma □Macular degeneration □Blindness
□Cataracts □Retinal detachment □Other eye condition:_____
□Diabetes □High blood pressure □Other medical condition:_____

How did you hear about us?
□Yelp □Internet □Referral (Who may we thank?_____) □Other_____