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_______________________