Family Optometry Center

Last Name_____ First Name _____ MI_____
Address_____ City _____ Zip _____
Telephone (Home)_____ (Work)_____
SSN_____ Date of Birth_____ Age_____
Occupation_____ E-Mail _____
Employer_____
Driver's License Number_____ Expiration Date_____
Date of last eye exam_____ Dilated?_____ Today's date_____
Are you interested in Laser Vision Correction? Y/N If yes, how soon?_____

MEDICAL INFORMATION

What is your general health?_____
Do you have problems with any of these systems? *(please circle all that apply)*

Eyes	Y / N				
Gastrointestinal	Y / N	Nervous	Y / N	Mental	Y / N
Ears/Nose/Throat	Y / N	Genitourinary	Y / N	Endocrine (glands)	Y / N
Cardiovascular	Y / N	Musculoskeletal	Y / N	Blood/lymph	Y / N
Respiratory	Y / N	Integumentary (skin)	Y / N	Allergic/immunologic	Y / N

Please explain_____
Please answer all that apply:
Diabetes Y / N Type_____ Date of diagnosis_____
Allergies Y / N Allergic to what?_____ What happens?_____
Medication allergy Y / N What happens?_____ Headaches Y / N
Other health problems_____
Current medication(s)_____
Have you had any operations? Y / N Kind?_____ When?_____

Name of family doctor_____ Date of last visit _____

FAMILY HISTORY

High blood pressure Y / N Relation_____ Macular degeneration Y / N Relation_____
Diabetes Y / N Relation_____ Retinal detachment Y / N Relation_____
Glaucoma Y / N Relation_____ Cataracts Y / N Relation_____
Other eye condition(s) Y / N What kind?_____ Relation_____

PERSONAL EYE INFORMATION

Have you had any eye operations? Y / N Type_____ Date_____
Have you had an eye injury? Y / N Kind_____ Date_____
Do you have glaucoma? Y / N Cataracts? Y / N Dry eyes? Y / N Blurred vision? Y / N
Other eye problems? Y / N What kind?_____
Do you wear glasses? Y / N Contact lenses? Y / N Type _____
Additional information_____
Whom may we thank for referring you? _____
Doctor's initials_____

Patient History
QUESTIONNAIRE