

NAME _____ **Date of Birth** _____

ADDRESS: _____

STATE: _____ **ZIP:** _____ **Phone:** _____ cell / home

E-MAIL _____

Interested in a FREE consultation for Laser Vision Correction? YES _____ NO _____

Interested learning about contact lens options? YES _____ NO _____

Primary Care Doctor _____ **City** _____ **State** _____
 (first and last name)

PCP phone number _____

Month/Year of your last appointment with your PCP? _____

MEDICATIONS (list medications taken daily or provide us a list to photocopy)

Medication _____ **Dosage** _____ **Reason for this medication** _____

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Medication _____ **Dosage** _____ **Reason for this medication** _____

Are you allergic to any medications: _____

Do you have any other allergies? _____

Have you ever had any of the following eye condition (s) :

<i>Glaucoma</i>	<i>Strabismus</i>	<i>Keratoconus</i>	<i>Patching</i>
<i>Macular Degeneration</i>	<i>Injury</i>	<i>Amblyopia (lazy eye)</i>	<i>Retinal Hole</i>
<i>Retinal Hole</i>	<i>Surgery</i>	<i>Inflammatory Disorder</i>	<i>Glaucoma Suspect</i>
<i>Retinal Degeneration</i>	<i>Cataract</i>	<i>Retinal Detachment</i>	<i>Other</i>

If other, please explain: _____

Smoking Status: Only some days: _____ Every day: _____ Former Smoker: _____ Never Smoker: _____

If current smoker, select preference:

Cigarettes: _____ **Cigars:** _____ **Pipe:** _____ **Smokeless Tobacco:** _____

Other: _____

Do you drink alcoholic beverages: Yes ____ No ____ Amount: _____ number per week

Hobbies: _____ (for customization of Eyeglass prescription)

Family History – please check all that apply

	Father	Mother	Brother	Sister	Son	Daughter
Cancer						
High Blood Pressure						
Thyroid						
Diabetes						
Amblyopia (lazy eye)						
Macular Degeneration						
Retinal Detachment						
Glaucoma						

Do you currently have any of the following conditions (circle):

Constitution

Cancer/Tumor
Fatigue Syndrome
Developmental Disability

Ear Nose Throat

Sinusitis
Laryngitis
Dry Mouth
Hearing Loss

Neurological

Cerebral Palsy
Multiple Sclerosis
Stroke
Epilepsy
Migraine
Autism Spectrum Disorder

Psychiatric

Depression
Anxiety Disorder
Attention Deficit
Bipolar Disorder

Cardiovascular

Vascular Disease
Hypertension
Stroke/CVA
Heart Disease
Congestive Heart Failure

Respiratory

Asthma
Chronic Obstruction
Emphysema
Cigarette Smoker
Sleep Apnea
Bronchitis

Gastrointestinal

Celiac Disease
Acid Reflux
Colitis
Ulcer
Crohn's
Irritable Bowel Syndrome

Genitourinary

Chlamydia
Prostate disease
Herpes
Pregnant
STD
Benign Prostate
Nursing
Kidney Disease

Musculoskeletal

Osteoporosis
Muscular Dystrophy
Osteoarthritis
Spondylitis
Gout
Fibromyalgia
Arthritis

Integumentary

Eczema
Rosacea
Herpes/Cold Sores
Herpes/Shingles
Psoriasis

Endocrine

Thyroid dysfunction
Type 2 Diabetes
Hormonal dysfunction
Type 1 diabetes

Hematological/Lymphatic

Ulcer
Anemia
Large Volume blood loss
Hypercholesterolemia
Hepatitis

Allergic / Immune

Lupus
Drug Allergies
Rheumatoid Arthritis
Sjogren's Syndrome
Environmental Allergy

Signature _____ Date: _____ Print Name _____

If under 18, Signature of responsible party above (Minor's name here _____)