Patient Name: _____ **Date of Birth:** _____

Gender: _____ **Last 4 SS #:**_____ **In School? Yes/ No** **If yes, what grade?** _____

Address: _____ **City:** _____ **State:** _____ **Zip:**_____

Email: _____ **Mobile Phone:** _____

Vision Insurance Carrier and ID #: _____

Medical Insurance Carrier and ID #: _____

How did you find us?: _____ **Hobbies:** _____

Occupation: _____ **Employer:** _____

What is the reason for your visit? _____

_____

Pregnant? Yes / No **Tobacco Use: Yes / No** **Alcohol Use: Yes / No** **Recreational Substance Use: Yes / No**

Contact lens use? Yes / No **What brand?** _____ **How often do you replace them?** _____

Are you interested in surgery for vision correction? Yes/ No **Do you feel your eyes look tired? Yes/ No**

Any Injuries, Traumas, or Surgeries: Yes/ No **If yes, please describe:** _____

Your Medications/ Vitamins/ Supplements (please provide list if available): _____

_____

Do you have allergies? Yes/ No **If yes, what are your allergies?**_____

Please check what applies:

Condition	Self	Family Member	Condition	Self	Family Member
Diabetes			Cancer		
High Blood Pressure			Autoimmune Disorder		
Thyroid Disease			Macular Degeneration		
Arthritis			Cataracts		
High Cholesterol			Glaucoma		
HIV/ AIDS			Lazy Eye		

Other conditions not listed: _____