



PATIENT NAME: _____

ADDRESS _____

PHONE _____ DATE OF BIRTH _____

Eye History

Circle "Yes" to indicate if you have any of the following:

Bloodshot Eyes	Yes	Floaters or Spots	Yes
Blurred Vision Distance	Yes	Glaucoma	Yes
Blurred Vision Near	Yes	Headaches	Yes
Burning Eye	Yes	Itching Eyes	Yes
Cataracts	Yes	Light Sensitive	Yes
Color Vision Poor	Yes	Loss of Vision	Yes
Crossed Eyes	Yes	Migraine Headaches	Yes
Discharge from Eyes	Yes	Night Vision Poor	Yes
Dizzy Spells	Yes	Red Eyes	Yes
Double Vision	Yes	Seeing Halos	Yes
Dry Eyes	Yes	Seeing Flashes	Yes
Eye Infection	Yes	Temporary Loss of Vision	Yes
Eye Strain	Yes	Twitching Eyelids	Yes
Fainting Spells	Yes	Vision Poor	Yes
Blackouts	Yes	Watering Eyes	Yes
Eye Injury	Yes	Latex Allergy	Yes

Health History

Circle "Yes" if you have any of the following:

AIDS	HIV+	Yes	Hepatitis A B C D	Yes
Arthritis		Yes	High Blood Pressure	Yes
Artificial Heart Valve		Yes	Kidney Disease	Yes
Artificial Joints		Yes	Lazy Eye	Yes
Asthma		Yes	Lupus	Yes
Bleeding		Yes	Migraine Headaches	Yes
Blindness		Yes	Pacemaker	Yes
Cancer		Yes	Poor Color Vision	Yes
Cataracts		Yes	Retinal Disease	Yes
Chemical Dependency		Yes	Rheumatic Fever	Yes
Diabetes		Yes	Shingles	Yes
Drug Sensitivity		Yes	Skin Conditions	Yes
Emphysema		Yes	Stroke	Yes
Epilepsy		Yes	Thyroid Conditions	Yes
Eye Surgery		Yes	Tuberculosis	Yes
Heart Condition		Yes	Turned Eye	Yes

Are you Pregnant? _____ Breast Feeding? _____ Use Tobacco _____ Use Alcohol _____

List all medications you are currently taking: _____

List all allergies to medications. Latex allergy: _____

Have you had any previous EYE SURGERY? _____
If yes please list: _____

Have you ever passed out during a medical procedure, dental procedure, or giving blood? Yes No

DO YOU HAVE VSP? _____ IF YES, NOTIFY FRONT DESK PRIOR TO SEEING THE DOCTOR

Payment today: Self Pay (Cash, Credit, Check) Filing Insurance

Patient Signature _____ Date: _____