Name: ______________________________ Today's Date: ______________

Address: ______________________________

____

____

Daytime Phone: ______________

Evening Phone: ______________

Social Security Number: ______________________ Date of Birth: ______________

Occupation: ______________________________ Employer: ______________

Please Check either YES or NO for each of the following questions.

Medical Problems (Medical history and Review of Systems):

Do you, your parents or siblings have any of the following?

	NO	YES	Relationship to you
Blindness	____	____	________________
Cataract	____	____	________________
Crossed Eyes	____	____	________________
Glaucoma	____	____	________________
Macular Degeneration	____	____	________________
Retinal detachment/disease	____	____	________________
Arthritis	____	____	________________
Cancer	____	____	________________
Diabetes	____	____	________________
Heart Disease	____	____	________________
High Blood Pressure	____	____	________________
High Cholesterol	____	____	________________
Kidney Disease	____	____	________________
Lupus	____	____	________________
Respiratory Disease	____	____	________________
Thyroid Disease	____	____	________________
Other	____	____	________________

Allergies: ____

____

List any medications you are taking including eye drops, vitamins and herbal supplements: ______________

____

List any previous surgery, hospitalizations, major illnesses, or injuries: ______________

____

Do you smoke? Yes / Quit / No

If yes, # of packs a day -

Do you drink alcohol? Yes No

If yes, # of drinks per week -

NOTE: If Insurance Benefits are used and we do not receive payment, the patient is liable for the balance due.

Patients Signature: ______________________________