Name____Date Of Birth____________________

Referred by: ______________________ Your Last Eye Examination was when:____________________

Explain the specific reason for your visit today:____

YOUR EYE HISTORY: EXPLAIN: (When?)

- ( ) Injury
- ( ) Surgery
- ( ) Cataract
- ( ) Glaucoma
- ( ) Other:
- ( ) **NO PREVIOUS EYE HISTORY**
- ( ) Tumor
- ( ) Crossed Eye
- ( ) Lazy Eye
- ( ) Retina Problems

YOUR MEDICATIONS

FOR YOUR EYES	ALL OTHER MEDICATIONS

MEDICINE ALLERGIES

and other allergies:____

PAST SURGERY AND DATES:

MEDICAL HISTORY: EXPLANATION: (When?)

- ( ) Diabetes
- ( ) High Blood Pressure
- ( ) Heart Disease
- ( ) Thyroid Condition
- ( ) AIDS, HIV Or Hepatitis
- ( ) Cancer
- ( ) Stroke
- ( ) TB
- ( ) Other
- ( ) **NONE**

FAMILY EYE HISTORY: EXPLANATION: (mother, father, etc.)

- ( ) Glaucoma
- ( ) Crossed Eye
- ( ) Cataract
- ( ) Retina Problems
- ( ) Diabetes
- ( ) Eye Cancer
- ( ) Other
- ( ) **NONE**

WHO IS YOUR PERSONAL MEDICAL PHYSICIAN / PEDIATRICIAN?____________________

Your Doctor's Phone Number____

WHO MAKES YOUR EYEGLASSES?____