First Name:	Last Name:	Date:
Nickname:	Date of Birth:	Occupation/Grade:

Do You Wear Contact Lenses?
Yes No
Brand:

Do You Have Diabetes?
(Circle One)
No Type 1 Type 2

Do You Smoke?
(Circle One)
No Currently Formerly

Emergy Contact info	Primary Care Physician	Last Eye Exam
Name:	Name:	Year:
Phone:	Town:	Doctor:

Circle any Past and Current Medical Conditions

Arthritis
Cancer
HIV
Hyperthyroid
Hypothyroidism
Immune Condition
Multiple Sclerosis
Anxiety/Depression
High Blood Pressure
High Cholesterol
Heart Disease
Kidney Disease
Other:

Circle any Past Eye Conditions

Glaucoma
Contact Lens Wear
Macular Degeneration
Elevated Eye Pressures
Retinal Tear/Detachment
Floaters
Eye Surgery
Eye Tumors
Allergy Eyes
Cataracts
Corneal Problems
Dry Eyes
Ocular Migraines

List Current Medications

_____

_____

_____

_____

List Any Medication Allergies

_____

_____

Circle Any Family History

Eye Turn/Lazy Eye
Glaucoma
Retinal Issues
Macular Degeneration

Circle What Brings You in Today

Check Up
Blurry Vision
Need Contacts
Eye pain/Concerns
Broken Glasses
Other: _____

Circle Any Current Symptoms

Poor Vision/Vision Changes
Trouble Seeing at Night
Eye Itchiness
Eye Pain
Tearing/Watery Eyes
Dry Eyes
Crusty Eyelids
Light Sensitivity
Double Vision
Floaters
Allergies
Headache
Weight Loss
Cough
Rapid Heart Beat
Shortness of Breath
Joint Pain