Last Name:____________ First Name:____________________ Exam Date:______________ Gender:________

Address:______________________________ City:____________________ St:_____________ Zip:________

Cell/Home Phone:______________________________ DOB:____________ SS#:____________________

Email:____

If patient is a minor, responsible party name:______________________________ Relationship:__________________

Reason for visit today:______________________ Last Physical:____________ Last Eye Exam:__________

Personal History:

Double Vision	Y	N
Headaches	Y	N
Eye Injury	Y	N
Eye Surgery	Y	N
Perceived streaks of light	Y	N
Light Sensitivity	Y	N
Perceived Floaters	Y	N
Eyes Itching/Burning	Y	N
Diabetes	Y	N
Hypertension	Y	N
Glaucoma	Y	N
Eye Disease	Y	N
Covid Vaccine	Y	N

Please list any **medications** you take :

____

____

____

Please list any **allergies** you have:

____

____

Are you currently **Pregnant** or have the possibility of Pregnancy? Y N

Are you Nursing? Y N

Any other health conditions:____

Family History:

Diabetes	Y	N	If yes,circle: Mother Father Grandmother Grandfather
Hypertension	Y	N	If yes,circle: Mother Father Grandmother Grandfather
Glaucoma	Y	N	If yes,circle: Mother Father Grandmother Grandfather
Eye Disease	Y	N	If yes,circle: Mother Father Grandmother Grandfather

Authorization for treatment and to pay benefits to physician: I hearby authorize the physician to release any information required to process my insurance claim. I also authorize my insurance benefits be paid directly to the physician, and I understand I am financially responsible for non-covered services. I give my permission to the doctor to do any medical testing they deem necessary

.**Signed:**______________________________ **Date:**____________________