TODAY'S VISION

Last Name: ________________________________First Name: __________________________________
Street Address: ____
City: _________________ State __________ Zip Code: ____________
Home Phone: ________________________ Daytime Phone (if different): _________________________
Cell Phone: ____________________________________ May we text you? □ Yes □ No
E-Mail Address: ____
Sex: □ M □ F Date of Birth: _______________ Social Security Number: ______________________
Marital Status: _____________________ Employment Status: __________________________________
Employer: _______________________________ Occupation: __________________________________
Last Eye Exam: ____________________________Doctor: ______________________________________

Race:
Native American/Native Alaskan □
Asian □
Black/African American □
Hispanic □
Native Hawaiian/Other Pacific Island □
White □

Do you currently wear contacts: □ Y □ N

Would you like to wear contacts? □ Y □ N

Have you worn them in the past? □ Y □ N

PATIENT HEALTH HISTORY

Primary Care Physician: ______________________________ Date Last Seen: ______________________
List all your medications (include over the counter, vitamins and herbal therapy):
____
____
List all major surgeries in the past five years:
____
____
List any allergic reactions to medications, eye drops or food: ___________________________________
____

Please indicate if any of the conditions apply to you or a family member (blood relatives only)

Disease Condition	Yourself YES	Yourself NO		Family Member YES	Family Member NO	Relationship (blood relatives only)
Cataract	□	□	Blindness	□	□	________________________________
Eye Turn	□	□	Eye Turn	□	□	________________________________
Glaucoma	□	□	Glaucoma	□	□	________________________________
Macular Degeneration	□	□	Macular Degeneration	□	□	________________________________
Retinal Detachment	□	□	Retinal Detachment	□	□	________________________________
Other:						

Women: Are you pregnant? □ Yes □ No Are you breast feeding? □ Yes □ No