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*** Certain browsers may not support the above functions ***

Name: _____

Height _____ Weight _____

Please list any medications you are taking or supply a list:

1.
2.
3.
4.

Drug Allergies: _____

Primary Care Doctor: _____

Female Patients: Are you Pregnant or Nursing? ☐ Yes ☐ No

Do you have a problem with any of the following:

High Blood Pressure/Cholesterol	☐ Yes	☐ No	Neurological	☐ Yes	☐ No
Ear/Nose/Allergies	☐ Yes	☐ No	Endocrine (Thyroid)	☐ Yes	☐ No
Respiratory	☐ Yes	☐ No	Blood/Lymph	☐ Yes	☐ No
Gastrointestinal	☐ Yes	☐ No	Do you smoke?	☐ Yes	☐ No
Musculoskletal	☐ Yes	☐ No	Drink Socially?	☐ Yes	☐ No

Diabetic or Pre-Diabetic ☐ Yes ☐ No How many Years? _____ Last A1C? _____

Have you been diagnosed with cancer or a tumor? If so, what area?

Family history: ☐ Macular Degeneration ☐ Glaucoma ☐ Retinal Problems ☐ Diabetes

Are you interested in a Contact Lens Exam? ☐ Yes ☐ No

Please be aware that a contact lens evaluation is not part of a **regular vision exam** and has an additional fee that may **NOT** be covered by your insurance _____ (please initial)

Do you have a problem with any of the following:

☐ Flashes ☐ Floaters ☐ Dry Eyes ☐ Watery Eyes ☐ Gritty Eyes ☐ Itchy Eyes ☐ Glare with Night Driving

Have you had cataract or any other eye surgeries? ☐ Yes ☐ No

If yes, please list date and surgeon:

Right Eye _____ Left Eye _____

Return Visit Reviews

Date: _____ Signature: _____

Date: _____ Signature: _____

Date: _____ Signature: _____