FAMILY OPTOMETRIC CARE
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Patient Information

Patient Name____ Date of Birth________________________

General Medical Doctor ______________________________ Address____________________________

Last Eye Exam _______________________________ Do you now or have you ever worn glasses? Y/N

Do you now or have you ever worn contacts? Y/N Are you interested in contacts? Y/N

What brand of contact lenses have you previously worn?_______________________________________

Are you Pregnant: Yes / No

Alcohol Use: Y/N Amount:_________________

Past Tobacco Use: Y/N Amount:____________

Current Tobacco Use: Y/N Amount:_________

List **Medications** you are currently taking and dosages if known:

Allergies to Medication:

Have you been diagnosed as having any of the following conditions?

_____Diabetes (Type I/Type II)
_____High Blood Pressure
_____Heart Disease
_____High Cholesterol
_____Asthma
_____Macular Degeneration
_____Kidney Disease
_____Thyroid Disease
_____Serious Head Injury
_____Allergies
_____Migraines
_____Glaucoma
_____Stroke
_____Cancer_______
_____TB
_____STD
_____Arthritis
_____Cataracts
_____Other:____

List those in your immediate family (Father, Mother, Brother, Sister, Son, or Daughter) who have been diagnosed with any of the following conditions:

_______Macular Degeneration
_______High Blood Pressure
_______Diabetes (Type I/Type II)
_______Glaucoma
_______Thyroid Disease
_______Cataracts
_______Cancer_____

Please check the following eye symptoms that presently apply:

_____Light Flashes
_____Floaters
_____Discharge from Eyes
_____Difficulty Seeing at Night
_____Episodes of Temporary Loss of Vision
_____Dryness
_____Burning
_____Light Sensitivity
_____Excessive Watering
_____Double Vision
_____Color Blindness
_____Trouble Reading
Other:_____________

Have you previously had any eye diseases, injury, or surgery? Y/N Please List:__________________

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