

PATIENT HISTORY

PATIENT NAME _____ GENDER (M/F) DATE _____ BIRTH DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE _____ EMAIL _____ PRIMARY PHYSICIAN _____

I consent to being contacted via text message/email. Yes / No (Please circle one)

PERSONAL MEDICAL INFORMATION (PATIENT ONLY). CHECK BOX IF YOU HAVE CONDITION

- | | | |
|--|--|--|
| <input type="checkbox"/> CARDIOVASCULAR (heart, blood pressure, etc) | <input type="checkbox"/> EAR/NOSE/THROAT | <input type="checkbox"/> GASTROINTESTINAL (digestive, etc) |
| <input type="checkbox"/> RESPIRATORY (lung, etc) | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> NERVOUS SYSTEM (stroke, etc) |
| <input type="checkbox"/> MUSCULOSKELETAL | <input type="checkbox"/> SKIN | <input type="checkbox"/> GENITOURINARY (bladder, etc) |
| <input type="checkbox"/> MENTAL/MOOD | <input type="checkbox"/> ENDOCRINE (diabetes, etc) | <input type="checkbox"/> BLOOD/LYMPH |
| <input type="checkbox"/> ALLERGIC/IMMUNOLOGIC | <input type="checkbox"/> SURGERIES | |

ARE YOU ALLERGIC TO ANY MEDICATION OR OTHER SUBSTANCES? YES / NO (circle one)

If yes, please list: _____

OTHER FACTORS

DO YOU SMOKE? Y/N (circle one) DO YOU DRINK ALCOHOL? Y/N (circle one)

DO YOU USE ANY RECREATIONAL DRUGS? Y/N (circle one)

DO YOU TAKE MEDICATIONS? Y/N (circle one)

LIST CURRENT MEDICATIONS (PRESCRIBED OR OTC): _____

DO YOU HAVE ANY OF THESE EYE CONDITIONS?

- | | | | | |
|---|--|--|---|------------------------------------|
| <input type="checkbox"/> DRY EYES | <input type="checkbox"/> EYE SURGERIES | <input type="checkbox"/> EYE INJURIES | <input type="checkbox"/> MACULAR DEGENERATION | <input type="checkbox"/> CATARACTS |
| <input type="checkbox"/> BLURRED VISION | <input type="checkbox"/> WEAR GLASSES | <input type="checkbox"/> WEAR CONTACTS | <input type="checkbox"/> RETINAL DETACHMENT | <input type="checkbox"/> GLAUCOMA |

DO YOU HAVE FAMILY HISTORY OF THESE EYE/MEDICAL CONDITIONS?

- | | | | |
|--|---|---|-----------------------------------|
| <input type="checkbox"/> EYE SURGERIES | <input type="checkbox"/> MACULAR DEGENERATION | <input type="checkbox"/> BLINDNESS | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> RETINAL DETACHMENT | <input type="checkbox"/> AMBLYOPIA (LAZY EYE) | <input type="checkbox"/> STROKE |

MY SIGNATURE SERVES AS WRITTEN CONSENT TO DILATION, ANY NECESSARY MEDICAL TEST/TREATMENT AND OR CONTACT LENS FITTING (ELECTIVE). THIS CONSENT APPLIES TO PARENT/GUARDIAN OF MINOR CHILDREN.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN (if applicable) _____ DATE _____

REVIEWED ___/___/___ REVIEWED ___/___/___ REVIEWED ___/___/___ REVIEWED ___/___/___ REVIEWED ___/___/___