Name:_____
Date of Birth:_____
Marital Status:_____
Are you employed?_____ Employer name:_____
Street Address:_____
City:_____
Zip Code:_____
Telephone:_____
SSN:_____
Email:_____

Do you have vision insurance? __Yes
Name of insurance_____
__No
Do you have health insurance? __Yes
Name of insurance_____
__No

Name:_____ DOB:_____DATE_____
Do you have any of the following visual symptoms?
__Blurred distance vision
__Blurred near vision
__eye pain
__eye strain
__excessive itching
__excessive burning
__excessive tearing
__flashes
__floaters
__headaches
__dry eye
__redness

Medical history
___heart disease
__diabetes-how long_____last blood sugar_____ last A1c_____
__thyroid problems
__breathing problems asthma, COPD
__arthritis
__GI problems
__high blood pressure
__high cholesterol
__Stroke
__Cancer
__HIV
__pregnant or nursing
__other_____
Family doctor_____
Known allergies:_____
List of
Medications_____
_____

Social history
Do you drive? Yes No
Any visual difficulties while driving? Yes No
If yes, please explain_____
Do you smoke? Yes No
Do you drink alcohol? Yes No
Do you use any recreational drugs? Yes No

Dilated exams are recommended to assess the health of the eyes. The dilation drops may make you blurry, especially up close for 4-6 hours. You may also have light sensitivity during this time.
___yes dilate my eyes today. ___no I do not wish to be dilated today

Signature:______________________________Date:________________