COMPREHENSIVE EYE EXAMINATION

PATIENT INFORMATION

LAST NAME _____ FIRST NAME _____ M F

OCCUPATION: _____

ADDRESS: _____ CITY: _____ State: Zip:

PHONE: _____ DOB: AGE: PREV. PATIENT? Y N

INSURANCE: _____ MEMBER ID # _____

PRIMARY'S NAME/DOB: _____ Last 4 of SS#: _____

EMAIL: _____ LAST EXAM: _____ Dr's Name.: _____

CONTACT WEARER: Y N TYPE: _____ WEARING TODAY: Y N

SMOKE: Y N ALCOHOL: Y N DRUGS: Y N DATE:

PATIENT MEDICAL and OCULAR HISTORY

	SELF	FAMILY	NONE		SELF	FAMILY	NONE
Diabetes	_____	_____	_____	Glaucoma	_____	_____	_____
Hypertension	_____	_____	_____	Cataracts	_____	_____	_____
Heart Disease	_____	_____	_____	Retinal Disease	_____	_____	_____
Hyperlipidemia (Cholesterol)	_____	_____	_____	Macular Degeneration	_____	_____	_____
Thyroid	_____	_____	_____	Eye Injury	_____	_____	_____
Asthma	_____	_____	_____	Eye Surgery	_____	_____	_____
Cancer	_____	_____	_____	Double Vision	_____	_____	_____
Urinary	_____	_____	_____	Frequent Headaches	_____	_____	_____
Arthritis	_____	_____	_____	Eyes Been Dilated?	Y N	YEAR:	_____
Skin Lesions/Disease	_____	_____	_____	Pseudophakia (Lens Implants)	Y N	OD OS	OU

PATIENT MEDICAL EVENTS, CURRENT MEDICATIONS, ALLERGIES

OCULAR MEDICATIONS (Rx or OTC):

OTHER MEDICATIONS (Rx or OTC):

POSITIVE FINDINGS:

ALLERGIES: