Personal Information

Name:	Date:	Chart #:

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ American Indian/Alaskan ☐ Hawwaiian/Pacific Islander ☐ Declined

Smoking History ☐ Current Every Day Smoker ☐ Current Some Day Smoker ☐ Never Smoked

☐ Unknown ☐ Former Smoker : Date Started Smoking__________________ Date Quit__________________

Medical Insurance:

Pharmacy to Send Prescriptions to:	Name:
	Address:
	Phone:

Medical History

Any Herpetic Eye Disease	N	Y	Pregnant / Nursing	N	Y
Connective Tissue Disorder	N	Y	Keloid Former	N	Y
Diabetes	N	Y	Hypertension	N	Y
Pacemaker	N	Y	Cancer	N	Y

Previous Eye Surgery: N Y Kind of Surgery:____

Medications

Are you allergic to any medications?	N	Y	If yes, please list:
Are you taking medications for your eyes?	N	Y	If yes, please list:
Are you taking any other medications?	N	Y	If yes, please list:

Eye History

How many years ago was your last eye examination:

Do you wear glasses? N Y if yes, for: Distance Reading Both Glasses are __________ years old

Do you wear contacl lenses? N Y If yes: Hard or Soft Wearing for __________ years

What date were your contact lenses last in your eyes? Date:____________________ or ☐ **I am wearing them now.**

Do you ever note halos around lights or problems with glare using you current contact lenses or glasses? No or mild moderate servere

Primary Care Physician/Family Doctor

Name:

Address

Rev 9/18/08