Please contact me by:

- ❑ Phone call
- ❑ Text
- ❑ Email

Today's Date:_______/_______/_________

First Name:____________________________ Initial:_________ Last Name:___________________________________

Date of Birth:_______/_______/__________ Social Security Number (Last 4 Digits): _____________________________

Address:____

Phone Number: ____________________________E-mail:____

Guardian/Emergency Contact:___________________________________Phone Number:_________________________

Date of last eye exam: ____

Chief Complaint: ____

Have you worn glasses? YES / NO How old are your current glasses? _________________

Have you worn contact lenses? YES / NO How old are your contacts? _________________

Do you have…

	Yes	No		Yes	No
High Blood Pressure			**Macular Degeneration**		
High Cholesterol			**Glaucoma**		
Diabetes			**Flashes and Floaters**		
Thyroid Condition			**Cataracts**		
Retinal Detachments			**Are you Pregnant or Nursing**		

MEDICATIONS: Please provide any prescription medications you are taking OR a copy of your medication list:

____

____

Please list any allergies to medications you are aware of:

____

Who is your primary care physician?_________________________________ Phone #: _________________________

Preferred Pharmacy: ____

Address: ____