Walnutport Family Eyecare ____________________ **Wind Gap Family Eyecare**

Name:____ Date of Birth:____________________________

Medications:: (**If you have a list, bring it to the front desk**) ____

____

Allergies to Medications:______________________________ Other Allergies:___________________________

Are you Diabetic? ☐Yes ☐No If yes, Who is your Diabetic doctor?____

Last blood sugar #:_____________ A1C:_____________

Are you pregnant or nursing? ☐Yes ☐No Diabetic Dr's Location? ___________________________

Do you have High Blood Pressure? ☐Yes ☐ No Do you have High Cholesterol ☐Yes ☐ No

Do you have a Heart Condition? ☐Yes ☐ No Any other Medical Problems? Explain :____________________________

Do you use Tobacco? ☐ Yes ☐ No Do you use alcohol? ☐ Yes ☐ No

Height: _________ Weight:___________ If applicable, last blood pressure reading: _______________________

Who is your primary care physician?_________________________________Location: ___________________________

Was your last eye exam here? ☐ Yes ☐ No If no, when was it? ______________________________

Are you having any problems with your eyes? ☐Yes ☐No If yes, Explain:_______________________________________

Are you getting new glasses today? ☐Yes ☐No Are you updating your contact lenses? ☐ Yes ☐ No

Emergency Contact:

Name:_____________________________Phone:______________________Relationship__________________________

Initial & Date: ________________