Walnutport Family Eyecare **Wind Gap Family Eyecare**

Name:_____ SS#_____

Date of Birth:_____ Male/ Female Race:_____

Workplace/School:_____ Occupation/Grade:_____

How did you hear about our office?_____

Last eye exam:_____ Where?:_____

Medications:_____

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? _____

Height: _____ Weight:_____ If applicable, last blood pressure reading: _____

Who is your primary care physician?_____Location: _____

Emergency Contact: Name:_____Phone:_____Relationship_____

Do you currently wear glasses? Yes / No Do you want new glasses today? Yes / No
Do you currently wear Contacts? Yes / No (Brand/strength?)_____
Do you need an updated contact lens exam to order more contacts? Yes / No

Do you struggle with your vision? Distance Near Both None

PATIENT HISTORY	**NO**	**YES**		**NO**	**YES**
Glaucoma	❍	❍	Eye Allergies	❍	❍
Cataracts	❍	❍	Headaches	❍	❍
Cataract Surgery	❍	❍	Floaters	❍	❍
Detached Retina	❍	❍	Flashes of light	❍	❍
Macular Degeneration	❍	❍	Light Sensitivity	❍	❍
High Cholesterol	❍	❍	Pain or irritation	❍	❍ Ex:_____
High Blood Pressure	❍	❍	Dry Eye	❍	❍
Cancer	❍	❍	**SOCIAL HISTORY**		
Heart Condition	❍	❍	Do you use the following?		
Scaring on Eyes	❍	❍	Tobacco Products	❍	❍
Surgery to eyes	❍	❍	Alcohol	❍	❍

Other_____

FAMILY HISTORY	**NO**	**YES**	
Blindness	❍	❍	Relation:_____
Cataracts	❍	❍	Relation:_____
Glaucoma	❍	❍	Relation:_____
Macular Degen.	❍	❍	Relation:_____
Diabetes	❍	❍	Relation:_____
Gestational Diabetes	❍	❍	Relation:_____
High Blood Pressure	❍	❍	Relation:_____
Heart Disease	❍	❍	Relation:_____
Color Blindness	❍	❍	Relation:_____

Date Updated:_____
_____
_____
_____