**WELCOME TO ANTIOCH EYE ASSOCIATES!**

**Patients Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Preferred Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Gender:** \_\_\_\_\_\_\_ **Parent/Guardian name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State**:\_\_\_\_\_\_\_ **Zip**: \_\_\_\_\_\_\_\_\_\_\_

**Phone:** **Home**: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Marital Status:** Single Married Divorced Widowed **Last 4 of SSN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employer**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary care Doctor**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City and State:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Can send records**

**Preferred Pharmacy**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City and state:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*PERSONAL EYE HEALTH:**

**Are you currently experiencing any of the following symptoms?**

Blurred near vision Blurred distance vision Double Vision Floaters/Flashes

Dryness/burning Blurred computer Vision Watering eyes Red eye/lid

Itchy Eyes Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current glasses wearer** Yes No **Contact lens:** Yes No **If yes,** **Brand**: \_\_\_\_\_\_\_\_\_\_\_\_

How often do you dispose of your contacts? \_\_\_\_\_\_\_\_\_ Date of last exam:\_\_\_\_\_\_\_\_\_\_\_

**Please list any eye injuries or diagnosed eye diseases**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eye Surgeries**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Ophthalmologist**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*PERSONAL MEDICAL HISTORY**

**Current Health Conditions (please check all that apply):**

**Cardiovascular: Skin: Psychiatric:**

Heart Disease Acne Rosacea ADHD

Elevated Cholesterol Dermatitis ADD

E

Hypertension Psoriasis Alzheimer’s

Hypertentionh

Heart Attack Eczema Anxiety

Stroke **Musculoskeletal:** Depression

**Endocrine:** Arthritis Dementia

Diabetes Down syndrome Learning Disability

Thyroid Disease Osteoporosis **Respiratory:**

**Immunologic: Neurological:** Asthma

Sjogrens Bell’s palsy Lung Disease

Lupus Headaches **Other:**

Tuberculosis Multiple Sclerosis Hearing impaired

Herpes Simplex/Zoster Seizure Disorder Cancer

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current medications/vitamins**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any medication or Environmental allergies**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any surgeries:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you pregnant or Nursing? Yes / No**

**\*SOCIAL HISTORY**

**Driving status:** Day and night Daytime onlyNone

**Alcohol:** Social 1-2 a day 3+ a day **Tobacco:** Never Current Former

**\*FAMILY HISTORY (of blood relation)**

Keratoconus Amblyopia (lazy eye) Glaucoma Macular Degeneration

Cataracts Retinal detachment Color Blind Thyroid Disease

Cataracts

Diabetes Heart Disease Stroke Heart attack

Cancer High Cholesterol Hypertension Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient or parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:\_\_\_\_\_\_\_\_\_\_