First name: _____ Initial: ___ Last name: _____

Today's date: _____,2020 Date of Birth: _____ Age: _____

Address:_____ Apt: ____ City: _____ State: _____ Zipcode: _____

Phone cell: _____ Phone work: _____ Phone home: _____

For your annual exam reminder please provide your email: _____

Social Security number: _____ Driver's license number _____

How did you find our office? _____ _____

Month/year of last eye exam: _____ Where: _____

Did you bring any glasses? _____ How old is the prescription in your glasses? _____

Do you use contact lenses? _____ When was your last contact lens exam? _____ Brand of CL? _____

Last time you wore contact lenses: _____ Do you sleep in your contact lenses? _____

Do you use glasses driving a car? _____ Do you have trouble seeing when you are in a car? _____

Please circle each if you ever had: Cataracts, Glaucoma, Eye Surgery, RK, LASIK, Lazy eyes, Crossed eyes, Bulging eyes, Eye Infections, Droopy eyelids, Corneal Disease, or Retina problems.

Please circle if you often have: Glare at Night, Blur at night, Spots, Light flashes, Double vision, Blurry vision, Distorted vision, Loss of vision, Loss of side vision, Eye Pains, Daytime Light sensitivity, Sties, Discharge.

Please circle if you do a lot of: Cell phone, Texting, Computer, Paperwork, Reading books, Kindle or iPad, Crafts, Video games, TV, Driving, Gym, Walking, Hiking, Running, Biking, Golf, Tennis, Baseball, Basketball, Football, Soccer, Fishing, Boating, Skating, Skiing, Volleyball, Rifle, Pistol.

Pupil Dilation is important to find out if you have inside your eyes any diseases, melanomas, or other disorders. The side effects of Pupil Dilation included blurry vision and Extreme light sensitivity. If you do not wish your pupils to be dilated, we do offer the Optomap Retinal Screening which has no side effects.

Please circle what you wish to be examined for: Eye Glasses, Contact Lenses (added cost), Optomap (added cost)

Medical History

Please mark if you or any family members (grandparents, parents, sibling, or children) have the following:

Disease/Condition:	No:	Yes:	Not sure:	Relationship to you:
Cataract	____	____	____	_____
Retina Detachment/disease	____	____	____	_____
Glaucoma	____	____	____	_____
Macular Degeneration	____	____	____	_____
Blindness	____	____	____	_____
Crossed/Lazy Eyes	____	____	____	_____
High Blood Pressure	____	____	____	_____
Diabetes	____	____	____	_____
COVID19	____	____	____	_____
High Cholesterol	____	____	____	_____
Arthritis	____	____	____	_____
Kidney disease	____	____	____	_____

Date of last medical checkup:_____ Name of your family doctor: _____

Please list any major hospitalizations or surgeries you have had:

Please list all Prescription and Non Prescription medications you take:

Do you use: Alcohol or Tobacco

Do you take Plaquenil: Yes or No

Do you have any Allergies to Medications: Yes or No. If Yes please explain:

Please circle if you have any of the following: Fever, Dry Cough, Shortness of Breath, Weight loss, Weight gain, Skin Problems, Eyestrain headaches, Migraine headaches, Seizures, Allergies, Sinus congestion, Runny nose, Dry mouth, Asthma, Bronchitis, Emphysema, COPD, Diarrhea, Constipation, HIV, Kidney, Bladder, Arthritis, Muscle Pain, Joint Pain, Hepatitis, Anemia, Bleeding, Immune problems, Psychiatric problems.

Absolutely Optical, Inc maintains strict privacy of each patient's medical and personal information. A complete copy of our Privacy Policy is posted in the exam room and available in print. Please sign that you have reviewed the "Notice of Privacy Practices"

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Signature Date 2020