Welcome & History Form

Name: ___________________________________ DOB: ____________________

Occupation:____

Employer:____

E-Mail Address:____

Home Telephone Number:____

Cell Phone Number:________________________________ Call______ Text______

Prefered Phone Number: Cell_____ Home_____

Current Home Address:____

Town___________________________ State_______________ Zip Code_________

Do you wear contacts? Y / N Do you have any interest in wearing contacts? Y / N

Primary Care Doctor:______________________ Town:__________ Ph:____________

Pharmacy: _____________________________ Town:________________________

Medications: ____

____

Drug, Food or Seasonal Allergies:_______________________________________

Past Diagnosed Eye Conditions: ____

Social History: Alcohol Consumption Y / N If yes how many per day (avg). ________

Current Smoker Y / N / Quit If yes how much per day _________________________

Do you currently wear glasses? Y / N Age of current pair of glasses _____________

Do you wear sunglasses? Y / N Hours per day on computer or smartphone________

Please see other side

Family History: **Circle ALL That Apply**

None Apply Unknown Adopted

Heart Disease	Self	Father	Mother	Brother	Sister	Son	Daughter
High Cholesterol	Self	Father	Mother	Brother	Sister	Son	Daughter
Cancer	Self	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type I	Self	Father	Mother	Brother	Sister	Son	Daughter
Diabetes Type II	Self	Father	Mother	Brother	Sister	Son	Daughter
High Blood Pressure	Self	Father	Mother	Brother	Sister	Son	Daughter
Hyperthyroidism	Self	Father	Mother	Brother	Sister	Son	Daughter
Hypothyroidism	Self	Father	Mother	Brother	Sister	Son	Daughter
Amblyopia (lazy eye)	Self	Father	Mother	Brother	Sister	Son	Daughter
Cataracts	Self	Father	Mother	Brother	Sister	Son	Daughter
Macular Degeneration	Self	Father	Mother	Brother	Sister	Son	Daughter
Glaucoma	Self	Father	Mother	Brother	Sister	Son	Daughter
Retinal Detachment	Self	Father	Mother	Brother	Sister	Son	Daughter