HOUSE OF OPTICAL

Date_____

Patient First Name (LEGAL) **Patient Last Name** **Middle**

Primary Care Physician **Phone#** **Fax#**

Preferred Pharmacy-Name **Location** **Phone#** **Fax#**

MEDICAL HISTORY

Circle all that you have, or are being treated for.

Diabetes Thyroid Blood/ Lymph

Blood Pressure Cardiac (Other)_____ Skin

Cholesterol Psychological Depression Anxiety

Diabetic Eye Disease Bladder Urinary Tract

Polycystic Ovary Syndrome (PCOS) Respiratory Asthma

Gastrointestinal Acid Reflux Allergy Sinusitis

Nervous System Multiple Sclerosis (MS) Ears Nose Throat

Muscles Cancer_____ Type_____

Other: _____ Melanoma

Please list all MEDICATIONS you are currently taking :

Please list MEDICATIONS you are ALLERGIC TO and what type of reaction :

Please List NON-medication Allergies :

Are you Pregnant or nursing? Yes / No

Do you use cigarettes/tobacco? Yes / No **Occupational hazards?** Yes / No

Do you drink alcohol? Yes / No **Do you need safety glasses?** Yes / No

Family History: Please Circle all that apply. Relationship

Diabetes _____ Glaucoma _____ Macular Degeneration _____

Cancer _____ Cataracts _____

Ocular History: Please Circle all that CURRENTLY apply

Blurred vision	Floaters	Dry eyes	Eye Pain
Double vision	Flashing lights	Sandy/Grittiness	Cataracts
Loss of vision	Itchy eyes	Mucous/Discharge	Macular Degeneration
Foreign body sensation	Watery eyes	Headaches	Glaucoma

Other:_____

Please List any current/previous eye injury, eye disease or eye surgery?

Emergency Contact

Name _____

Phone_____ Relationship to Patient_____

EG Rx ***CL Rx***