Patient Form Exam Date:______________

Name: Last:___________________________First:________________________DOB:____________

Address:____Doctor/ Single/ Married/ Male/ Female

City:_______________________ State:_______ Zip Code:_________ Occupation:________________

Phone: Home____________________Work ______________________Cell______________________

Email:______________________________________ Preferred Contact: Home / Work / Cell

Race: White/Black/American Indian/Asian/Other:_____________Ethnicity: Hispanic/Non-Hispanic

Language (preferred): English/Mandarin/Cantonese/Spanish/Hindi/Russian/Other:______________

Guardian Name: ____________________________________ Father/Mother/Grandparent/Other/M/ F

Reason for Visit: ____Refer by:_______________

Leisure Activities: ____

Eye History month / day / year Vision Ins: ____________________SS/ID: ________________

Last Eye Exam:____________________Eye Care Physician: ____________________________________

<u>Circle all that apply:</u>	Self	Family	If yes, relationship, when, type, and treatment?
Glaucoma.	Yes / No	Yes / No	________________________
Cataract	Yes / No	Yes / No	________________________
Macular Degeneration	Yes / No	Yes / No	________________________
Dry Eyes	Yes / No	Yes / No	________________________
Floaters	Yes / No	Yes / No	________________________
Blurred Vision	Yes / No	Yes / No	________________________
Eye Injury	Yes / No	Yes / No	________________________
Surgery (ie, C-section)	Yes / No	Yes / No	________________________
Hypertension	Yes / No	Yes / No	________________________
Diabetes	Yes / No	Yes / No	________________________
Cholesterol	Yes / No	Yes / No	________________________

Other Eye Conditions: ____

Medical History month / day / year Health Ins: ______________________ID:________________

Last Health Exam:________________Primary Care Physician:_______________________________

Describe any problems and Medications: __________________________Flex Spending___________

Do you have problems with any of these systems? (*Please check all that apply.*):

Allergic/Immunologic	❑	Endocrine	❑	Integumentary (Skin)	❑
Cardiovascular	❑	Gastrointestinal	❑	Musculoskeletal	❑
Constitutional	❑	Genitourinary	❑	Neurological	❑

Please turn off cell phone prior entering the exam room.

It is a pleasure to serve you and your family here at Vision 27.