WOODBRIDGE EYE CARE

Welcome to our office. Please fill out this form to the best of your knowledge.

□ Mrs. □ Ms. □ Mr. □ Dr. □ Male □ Female

PATIENT INFORMATION

Name: _____
Last First Middle

Address: _____ □ Single □ Married □ Divorced □ Widowed
Street APT #

_____ Date of birth: _____ Age: _____
City State Zip Code

Home phone: _____ Cell or work: _____

Email: _____ MAY WE SEND YOU EMAILS? □ Yes □ No Occupation: _____

Whom may we thank for referring you? _____

Parent or Guardian's name if patient is under 18 years of age: _____

OCULAR AND MEDICAL HISTORY

Last Eye Examination: _____ Name of last eye doctor: _____

Last Medical Exam: _____ Name of Primary Care Physician: _____

Do you wear glasses: Yes / No Type _____ Do you wear contacts: Yes / No

Type of contact lenses: soft lenses / hard lenses Brand of contacts: _____ Power: _____

Are you here for: Contacts / Glasses / Both / First eye exam / Other: _____

PLEASE CHECK ALL THAT APPLIES:

	Yourself	Family		Yourself	Family
Blurry at distance	□				
Blurry at near	□		Healthy, no medical conditions	□	□
Headaches/Eyestrain	□		Diabetes	□	□
Dry Eyes	□		High blood pressure	□	□
Watery eyes	□		Heart conditions	□	□
Itchy eyes	□		Asthma/Respiratory conditions	□	□
Sensitivity to light	□		Sinus problems	□	□
Floaters/Spots	□		Arthritis	□	□
Flashes of lights	□		Cancer	□	□
Eye injury	□		Thyroid condition	□	□
Eye surgery	□		Bleeding problems	□	□
Double vision	□		Anemia	□	□
Lazy eye/amblyopia	□	□	Seizures	□	□
Retinal detachment	□	□	Other health conditions	□	□
Glaucoma	□	□			
Cataracts	□	□	Do you use **tobacco** products? Yes / No How much: _____		
Macular degeneration	□	□	Do you drink **alcohol**? Yes / No Drinks per week: _____		
Other eye conditions	□	□	Please list **all surgeries** you have had: _____		

Have you ever **been exposed to or infected** with: □ HIV □ AIDS □ Herpes □ Hepatitis □ Syphillis □ Gonorrhea
□ OTHER: _____ □ NONE

Please list **MEDICATIONS** (including birth control, vitamins, over the counter meds, home remedies, and eye drops):

_____

Please list all medications you are **ALLERGIC** to: _____

Seasonal allergies: Yes / No Please list any other allergies you may have (example: latex): _____

If applicable, are your pregnant and / or nursing?: Yes / No If yes, how many weeks/months along are you? _____