

Augustin Eye Care

Name _____ Date _____

Address _____ Birth Date _____ Age _____

City _____ State _____ Zip code _____ Last 4 Digits SSN _____

Phone:() _____ Email _____

Employer _____ Occupation _____

How did you hear about us? Referral Newspaper Sign Internet Television Postcard Previous Patient

Other _____

Are you interested in new **glasses / contact lenses / both?** (Circle)

Do you currently wear contacts? **Yes / No** Which type? _____

What is the reason for your visit today? _____

Primary medical doctor _____

Current Medications _____

Do you have any allergies to any medications? _____

Are you pregnant or breastfeeding? **Yes / No**

EYE INFORMATION (Check all that apply)

Cataracts	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Crossed Eyes	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Glaucoma	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Keratoconus	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Macular	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Blindness	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Eye Surgery	Self <input type="checkbox"/>	Family <input type="checkbox"/>	Degeneration			Retinal	Self <input type="checkbox"/>	Family <input type="checkbox"/>
Amblyopia	Self <input type="checkbox"/>	Family <input type="checkbox"/>				Disease		
(Lazy Eye)								

ARE YOU EXPERIENCING ANY OF THE FOLLOWING? (Check all that apply)

Dry Eyes <input type="checkbox"/>	Blurry Vision <input type="checkbox"/>	Double Vision <input type="checkbox"/>	Itchy Eyes <input type="checkbox"/>
Flashes of Light <input type="checkbox"/>	Floaters <input type="checkbox"/>	Watery Eyes <input type="checkbox"/>	Sensitivity to Light <input type="checkbox"/>
Redness <input type="checkbox"/>			

REVIEW OF SYSTEMS (Check all that apply)

Heart Problem Self <input type="checkbox"/> Family <input type="checkbox"/>	Cancer Self <input type="checkbox"/> Family <input type="checkbox"/>
Vascular Disease Self <input type="checkbox"/> Family <input type="checkbox"/>	Thyroid Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>
Seasonal Allergies Self <input type="checkbox"/> Family <input type="checkbox"/>	Urinary Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>
Rheumatoid Arthritis Self <input type="checkbox"/> Family <input type="checkbox"/>	Blood Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>
High Blood Pressure Self <input type="checkbox"/> Family <input type="checkbox"/>	Respiratory Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>
High Cholesterol Self <input type="checkbox"/> Family <input type="checkbox"/>	Multiple Sclerosis Self <input type="checkbox"/> Family <input type="checkbox"/>
Diabetes Self <input type="checkbox"/> Family <input type="checkbox"/>	Psychiatric Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>
GI (Stomach) Disorder Self <input type="checkbox"/> Family <input type="checkbox"/>	Other Major Illness Self <input type="checkbox"/> Family <input type="checkbox"/>

If you answered YES to any of the above or have a condition not listed, please explain

SOCIAL HISTORY (This information will be kept strictly confidential)

Do you use tobacco products? **Y/N** Do you drink alcohol? **Y/N** Do you currently drive? **Y/N**

Do you use illegal drugs? **Y/N**