DATE:____________

NAME:________________________, ________________________, ________________________
LAST *FIRST* *MIDDLE*

ADDRESS:____

CITY: ____________________ STATE: __________ ZIP: __________

DATE OF BIRTH : ____/____/____ PHONE #: ______-______-________

MEDICARE #:____________________ EMAIL:________________@__________.com

GENERAL HEALTH (CIRCLE ONE)			MEDICATIONS (PLEASE LIST)	MEDICAL ALLERGIES (PLEASE LIST)
High Blood Pressure?	Yes	No	____________________	____________________
Heart Trouble?	Yes	No	____________________	____________________
Diabetes?	Yes	No	____________________	____________________
Stroke?	Yes	No	____________________	____________________
Arthritis?	Yes	No	____________________	____________________

FAMILY HEALTH HISTORY (CIRCLE ONE)

Does any Blood Relative have a history of the following diseases or conditions?

High Blood Pressure?	Yes	No
Heart Trouble?	Yes	No
Diabetes?	Yes	No
Stroke?	Yes	No
Glaucoma?	Yes	No
Retinal Disease?	Yes	No
Blindness?	Yes	No

Other:______________________________

PERSONAL OCULAR HEALTH HISTORY(CIRCLE ONE)

Did you have good vision growing up?	Yes	No
Were glasses required for good vision?	Yes	No
Lazy Eye?	Yes	No
Eye turning in or out?	Yes	No
Injury to the eye?	Yes	No
Eye Surgery?	Yes	No
Have you ever seen "floating" objects?	Yes	No
Are you troubled by flashing lights?	Yes	No
Have you been told you have a Cataract?	Yes	No

Are you here to be fitted and prescribed Contact Lenses? Yes No

Dr. Jason Eugenides