Welcome to our office! Please complete the following health history questionnaire.

Last Name	**First Name**	**Middle Name**
Date of Birth	**Age**	**Male / Female**
Address	**City**	**Zip Code**
Home Phone Number	**Cell Phone Number**	
SS # or Member ID (for billing purposes)	**Email**	

Ocular History

Reason for your visit: _____

Last eye exam? _____ Where?_____

Do you wear contact lenses? □ Yes □ No

If yes, what type/brand? _____

Are youexperiencing any of the following eye/vision problems? (Check all that apply)

□ Trouble with distance vision
□ Trouble with near vision
□ Trouble with computer vision
□ Excessive tearing/watering
□ Excessive irritation
□ Previous eye surgery
□ Previous eye injury
□ Flashes of light
□ Dryness with Eyes
□ Red Eyes
□ Burning/Itchy Eyes
□ Discharge in eyes
□ Other:

□ Double Vision
□ Floaters
□ Loss of vision
□ Glaucoma
□ Cataracts
□ Macular Degeneration
□ Retinal Detachment
□ Strabismus/Eye Turn
□ Eye Pain or Soreness
□ Glare/Light Sensitivity
□ Tired Eyes
□ Headaches

Are you interested in laser vision correction? □ Yes □ No

Medical History

Are you currently being treated for any of the following medical conditions:

□ Diabetes	□ Heart Disease	□ Thyroid disease
□ Cancer	□ High blood pressure	□ Kidney disease
□ Arthritis	□ High cholesterol	□ Other:

Last physical examination _____ Dr.'s name_____

Medications you currently take:_____
_____
Allergies? _____
_____

Social History

Are you a smoker?	□ Yes	□ No
Do you use recreational drugs?	□ Yes	□ No
Do you drink alcoholic beverages?	□ Yes	□ No

If yes to any of the above, please describe type, amount and how long:
_____

Family Ocular History and Medical History

Please note any family history for the following eye conditions/diseases:

	Who?
□ Blindness	_____
□ Strabismus (Crossed Eyes)	_____
□ Glaucoma	_____
□ Macular Degeneration	_____
□ Retinal Detachment	_____
□ Arthritis	_____
□ Cancer	_____
□ Diabetes	_____
□ Heart Disease	_____
□ High blood pressure	_____
□ Kidney disease	_____
□ High cholesterol	_____
□ Thyroid disease	_____
□ Other:	_____

I acknowledge that I received a copy of Mary Demirjian, O.D. notice of privacy practices.

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Patient Signature Date