Legal Name_______________________________________ **Preferred Name** ____________________

Date of Birth ______________ **Height** _________**Weight** _______ **Marital Status:** Single Married Divorced Widowed

Primary Care Physician ____________________________ **Preferred Pharmacy**________________________________

Preferred Language: (please circle one)

English Spanish Russian Polish
Portuguese Italian Chinese
Japanese French Mandarin

Race: (please circle one)

White Asian American Indian/ Alaska Native
Black/ African American Pacific Islander Other

Ethnicity: (please circle one)

Hispanic or Latino
Not Hispanic or Latino

Review of Systems: (Please circle if you have any of the following conditions)

Developmental Disabilities	Attention Deficit Disorder	Acid Reflux	Gout	Sjogren's Syndrome
Cancer	Anxiety Disorder	Celiac Disease	Eczema	Drug Allergies
Fatigue Syndrome	Bipolar Disorder	Kidney Disease	Rosacea	Environmental Allergies
Hearing Loss	Hypertension	Prostate Disease	Psoriasis	Other ____________
Sinusitis	Heart Disease	STD - Herpetic/Chlamydia	Herpes Simplex/ Cold Sores	Other ____________
Dry Mouth	Vascular Disease	Benign Prostate Hypertrophy	Herpes Zoster/ Shingles	Other ____________
Laryngitis	Congestive Heart Failure	Pregnant	Type 2 Diabetes Mellitus	Other ____________
Multiple Sclerosis	Cigarette Smoker	Nursing	Type 1 Diabetes Mellitus	Other ____________
Epilepsy	Asthma	Herpes	Thyroid Dysfunction	
Cerebral Palsy	Bronchitis	Chlamydia	Hormonal Dysfunction	
Tumor	Emphysema	Osteoarthritis	Anemia	
Stroke CVA	Chronic Obstruction	Arthritis	Large -volume blood loss	
Migraine	Sleep Apnea	Fibromyalgia	High Cholesterol	
Autism Spectrum Disorder	Crohn's	Muscular Dystrophy	Rheumatoid Arthritis	
Depression	Colitis	Ankylosing Spondylitis	Lupus	
	Ulcer	Osteoporosis		

Other Medical Concerns:
____
____

Please list medications and allergies on next page.

Do you have a Latex Allergy: Yes No

Ocular History: (Please circle if you have any of the following conditions)

Amblyopia/ Lazy Eye Glaucoma Strabismus / Eye Turn Keratoconus Inflammatory Disorder Retinal Detachment Retinal Hole
Patching Age-related Macular Degeneration Cataract Nystagmus Retinal Degeneration
Eye Injury – type & date ______________________ Previous Eye Surgery – type & date ______________________

Family History: **(Check which family members have or had any of the following conditions)**

Condition						
Cancer	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Diabetes Type 1	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Diabetes Type 2	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Hypertension	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Hyperthyroidism	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Hypothyroidism	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Cataract	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Macular Degeneration	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter
Glaucoma	□ Father	□ Mother	□ Brother	□ Sister	□ Son	□ Daughter

Social History:

Do you use alcohol? Yes No
If yes , Amount______________
Do you use tobacco?
Never Previously
Yes, Some Day Yes, Every day
If yes, do/did you use:
Cigarettes Cigars Pipe
Smokeless Tobacco
Amount_________________
For How long?______________

Specific visual demands for work, school or hobbies: ______________________________

I acknowledge that I have been aware of the HIPAA Compliance Policy of Eye Care of the Big Horns, LLC.

______________________________________ ______________________

Signature of patient or parent if patient is a minor **Date**

Medication	**Dosage/Strength:**	**How Often:**	**What it's used for:**
EyeDrops used Over the counter or RX			

Allergy:	**Mild, Moderate, Sever, (Please circle one)**	**Symptoms**	**Comments**
	Mild Moderate Severe		
	Mild Moderate Severe		
	Mild Moderate Severe		