LAKE MERRITT
OPTOMETRY

Name _____ Nickname _____

Birthdate _____ SSN_____ Marital Status _____

Phone _____ Home/ Cell/ Work Alt. Phone _____ Home/ Cell/ Work

Address _____

Email _____ Preferred Contact Phone/ Email/ Mail

Male ___/Female___ Language/ Race/ Ethnicity_____

Last Eye Exam _____ Currently wear glasses? _____

Age of current glasses? _____ Currently wear contacts? _____

Brand of current contacts? _____

Reason for visit? _____

Have you or a family member experienced, or been treated for any of the following? Check all that apply.

	Self	Family	Neither
*Cataracts	___	___	___
*Crossed Eye	___	___	___
*Glaucoma	___	___	___
*Lasik or RK	___	___	___
*Lazy Eye	___	___	___
*Macular Degeneration	___	___	___
*Retinal Detachment	___	___	___
AIDS/ HIV	___	___	___
Allergies	___	___	___
Arthritis	___	___	___
Asthma	___	___	___
Blood/Lymph Disorder	___	___	___
Cancer	___	___	___
Diabetes	___	___	___
Ears, Nose, Throat	___	___	___
Gastrointestinal Condition	___	___	___
Heart Disease	___	___	___
High Blood Pressure	___	___	___
High Cholesterol	___	___	___
Kidney Disease	___	___	___
Lupus	___	___	___
Neurological Conditions	___	___	___
Psychiatric Disorder	___	___	___
Seizures	___	___	___
Skin Conditions	___	___	___
Stroke	___	___	___
Thyroid Dysfunction	___	___	___

Are you currently experiencing or have experienced any of the following. Circle all that apply.

-Blurry Vision -Burning -Discharge

-Double Vision -Dryness -Eye Infection

-Excess Tearing/ Watering -Eye Pain/Soreness

-Floaters/ Spots -Halos -Headaches

-Itching -Light Flashes -Light Sensitivity

-Redness -Sandy/Gritty Feeling

Current Medications (Prescription and OTC)

_____

_____

_____

Medication/Drug Allergies

_____

_____

Are you pregnant/nursing? Yes No

Do you smoke? Yes No

Have you ever smoked? Yes No