Today's Date: ____________________

Reviewed Date: ____________________

Reviewed Date: ____________________

Reviewed Date: ____________________

First: ____________________ MI: ____ Last: ____________________ DOB: ______________ Age: ________

SS #: ________________________________ Height: _________ Weight: _________ Sex: M ____ F ____

Current Marital Status: Single ____ Married ____ Divorced ____ Separated ____ Widowed ____

Home Address: __________________________ City: __________________ State: _____ Zip: __________

Primary Phone #: ______________________________ Email: __________________________________

Insurance Name: ______________________________ Member ID: ______________________________

PCP Name: __________________________________ PCP Phone #: ______________________________

Pharmacy Name: _______________________ Pharmacy Phone #: ______________________________

Reason for today's visit: ____

Are you currently experiencing any of the following: (Please mark all that apply)							
Blurry/Decreased Vision		Eye Injury		Growth/Bump on Lid		Watery Eyes	
Double Vision		Eye Pain/Burning		Headaches		None Apply	
Droopy Lid		Flashes of light/Floaters		Itchy Eyes/Lids		Other:	
Dry Eyes		Glare/Light Sensitivity		Red Eye(s)			
Past Ocular History: (Please mark all that apply)							
NONE		Dry Eyes		Macular Degeneration		None Apply	
Amblyopia (Lazy Eye)		Glaucoma		Optic Neuritis		Other:	
Cataracts		Iritis		Retinal Detachment			
Diabetic Retinopathy		Keratoconus					
Ocular Surgeries: (Please mark all that apply)							
NONE		Foreign Body Removal		Punctal Plugs		None Apply	
Blepharoplasty (lid surgery)		Glaucoma Laser Surgery		Retinal Laser (Diabetes)		Other:	
Cataract Surgery		LASIK/PRK/RK		Strabismus Surgery (Eye Muscle Surgery)			
Corneal Transplant		Ptosis Repair					
Medical Illnesses: (Please mark all that apply)							
NONE		Graves Disease		Lung Disease		Shingles	
Asthma		Headaches/Migraines		Lupus		Stroke	
Bell's Palsy		Heart Attack		MRSA		None Apply	
Brain Tumor		Herpes Simplex		Multiple Sclerosis		Other:	
Cancer		HIV+/AIDS		Myasthenia Gravis			
Congestive Heart Failure		High Blood Pressure		Osteoarthritis			
COPD/Emphysema		High Cholesterol		Rheumatoid Arthritis			
Depression		Hyperthyroidism		Seizures			
Diabetes		Hypothyroidism		Sickle Cell			

Please continue on the back side of this page

Family History: (Please mark all that apply)							
Blindness		Eye Misalignment		Lazy Eye (Amblyopia)		None Apply	
Cancer		Glaucoma		Macular Degeneration		Other:	
Cataracts		Heart Disease		Retinal Detachment			
Diabetes		Hyperthyroidism					

Allergies: (Please list known drug/environment/food allergies you have)		
Latex		Other:
Penicillin		
Sulfa Drugs		

Systemic Medications: (Please list all OTC/prescription medications you take, including strengths/dosages)
Please see list provided (Please provide list on separate page)

Ocular Medications: (Please list all eye medications you take including strengths/dosages)

General Surgeries/Operations: (Please include dates performed and request separate page if necessary)

Social History:	
Do you smoke? Y____ N____ Packs/Day____ Have you ever smoked? Y____ N____ Packs/Day____	
Do you drink alcohol? Y____ N____ Glasses/Bottles per day/week____	**Drug Use? Y____ N____**
Occupation:____________________	**Frequency of Use:**
Are you currently pregnant or nursing? Y____ N____	**Daily____ Weekly____ Occasionally____**

Hispanic		**Non-Hispanic**		**Other**	
American Indian/Alaskan		**Asian**		**Black/African American**	
Caucasian		**Hawaiian/Pacific Islander**		**Unknown**	

____ ____________________

Patient or Parent/Guardian Signature **Date**

I, ____________________ Hereby authorize Charm City Optical and Charm City Eye Care and/or any medical facility related to them to release any and all medical information and test results that pertain to me to the following individual(s) in the event that I am unable to be reached by the facility. I understand that I may revoke/cancel/change this authorization by notifying Charm City Optical and/or Charm City Eye Care in writing of my intent prior to any visits or additional testing/procedures being done.

Name:____________________ Phone #:____________________ Relationship to Patient:____________

____ ____________________

Patient or Parent/Guardian Signature **Date**