WELCOME TO EYE 2 EYE FAMILY OPTOMETRY!

For faster service, please complete the following form prior to arriving at our office.

*****PLEASE GIVE ANY GLASSES YOU HAVE TO THE STAFF DURING CHECK-IN*****

Name: _____ Preferred Name: _____ Sex: _____

DOB: _____ Phone: _____ ▢ Home ▢ Cell

Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

CURRENT HEALTH:

Primary Care Doctor: _____ Name of Medical/Health Insurance: _____

X all that apply: ▢ Diabetes ▢ High Blood Pressure ▢ High Cholesterol ▢ Hearing Loss ▢ Stroke ▢ Migraines

▢ Depression ▢ Bipolar ▢ Anxiety ▢ Heart Disease ▢ Thyroid ▢ Asthma ▢ Emphysema ▢ Sleep Apnea

▢ Fibromyalgia ▢ Gout ▢ Rosacea ▢ Psoriasis ▢ Eczema ▢ Cancer: _____ ▢ None

Pregnant: **Y N** Nursing: **Y N** Tobacco: **Y N** Drinking: **Y N**

OCULAR HISTORY:

Date of last eye exam if elsewhere: _____

X all that apply: ▢ Eye disease ▢ Surgery ▢ Injury ▢ Other ▢ None

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FAMILY HEALTH: (PARENTS/SIBLINGS/CHILDREN ONLY)

▢ Diabetes ▢ High Blood Pressure ▢ Cancer ▢ Glaucoma ▢ Macular Degeneration ▢ Retinal Detachment ▢ None

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MEDICATIONS/ALLERGIES:

Please list allergies: **X** if none ▢ Allergy to Latex: **Y N**

Please list Current Medications: ▢ **X** if none