PATIENT FORM

Allied Eyecare

GENERAL INFORMATION

Name

Street Address & City

Phone 1, type

Phone 2, type

Email

Social Security Number

Date of Birth

Male/Female

Occupation/Employer full-time I part-time

Marital Status married I single I divorced I widowed

Emergency Contact

Medical History

Primary Care Physician:

Current Medications

Are you currently pregnant or nursing?

Do you smoke? Have you ever?

List all allergies

over

Have you or a family member been treated for any of the following? If yes, circle self or family.

Cataracts	self	family
Crossed eye	self	family
Glaucoma	self	family
Lasik or RK	self	family
Lazy eye	self	family
Macular degeneration	self	family
Retinal detachment	self	family
Aids/HIV	self	family
Arthritis	self	family
Asthma	self	family
Blood/Lymph Disorder	self	family
Cancer	self	family
Diabetes	self	family
Ears/nose/Throat Conditions	self	family
Gastrointestinal Conditions	self	family
Heart Disease	self	family
High Blood Pressure	self	family
High Cholesterol	self	family
Kidney Disease	self	family
Lupus	self	family
Neurological Disease	self	family
Psychiatric Disorder	self	family
Seizures	self	family
Skin Conditions	self	family
Stroke	self	family
Thyroid Dysfunction	self	family