Press ctrl P to Print

Patient Form

Please fill out completely and bring in to your appointment

Name: *last*_____ *first*_____

Email:_____

Occupation:_____

Birth date:_____Today's date:_____

Reason for visit:_____Last eye exam was?_____

GENERAL HEALTH and EYE HISTORY

	YES	NO
HIGH BLOOD PRESSURE	____	____
DIABETES	____	____
CANCER	____	____
HEART DISEASE	____	____
THYROID DiSEASE	____	____
BREATHING TROUBLE	____	____
HEADACHES	____	____
ITCHY EYES	____	____
BURNING EYES	____	____
DOUBLE VISION	____	____
GLARE	____	____
ALLERGIES	____	____

FAMILY HEALTH HISTORY

	YES	NO
DIABETES	____	____
GLAUCOMA	____	____
MACULAR DEGENERATION	____	____
EYE TURNS	____	____
CATARACTS	____	____

LIST OF ALL MEDICATIONS: _____

ANY HISTORY OF EYE INJURY OF EYE SURGERY? YES ☐ NO ☐
If Yes, please describe_____

ARE YOU A COMPUTER USER? YES ☐ NO ☐ Hours per day?_____

ARE YOU INTERESTED IN CONTACT LENSES? YES ☐ NO ☐

2167 North Pontiac Trail, Commerce Twp, MI 48390
Phone: 248-960-2200