RENAISSANCE EYE CARE

Patient Name_____ Date of Birth_____
Social Security Number_____ Home Phone_____
Cell Phone_____

Medical History: Check the box if you have any of the following	
☐ Allergies/Hay Fever	☐ Hepatitis
☐ Asthma	☐ HIV/AIDS
☐ Arthritis	☐ Hypertension (high blood pressure)
☐ Cancer what type_____	☐ Hypercholesterolemia (high cholesterol)
☐ Depression	☐ Kidney Disease
☐ Diabetes what type _____	☐ Lupus
how long _____	☐ Thyroid Disease
☐ Emphysema or COPD	☐ Sexually Transmitted Disease
☐ Epilepsy	☐ Sjogren's Disease
☐ Hearing Loss	☐ Stroke
☐ Heart Disease	☐ Stomach Ulcers
☐ Headaches/Migraines	☐ Tuberculosis
☐ Hearing Loss	☐ Other:

Please list ALL medications that you take and drug allergies. (include vitamins and over-the-counter etc.)

MEDICATION	DOSAGE	MEDICATION	DOSAGE

Please list any drug allergies: _____

Personal Eye Information:

Have you ever had any eye surgery? Y/N Type _____ Date _____ Eye _____
Have you ever had an eye Injury? Y/N Type _____ Date _____ Eye _____
Do you have: **Glaucoma**? Y/N **Cataracts**? Y/N **Dry Eyes**? Y/N **Blurred Vision**? Y/N
Do you wear: Glasses? Y/N Contacts? Y/N Type _____
Additional eye information _____

Other:

Do you use tobacco? Y/N Type: cigarette/ pipe/ chew Are you pregnant? Y/N or nursing? Y/N
Do you drink alcohol? Y/N Type: _____

Family History: If any blood relative has ever had any of the following, please check the box and indicate relationship.

☐ Hypertension	☐ Cataracts
☐ Diabetes	☐ Retinal Detachment
☐ Glaucoma	☐ Lazy eye/s or Crossed eyes
☐ Macular Degeneration	☐ Other eye condition:

Patient Signature: _____ **Date:** _____