WELCOME TO SHENANDOAH EYE CLINIC

PATIENT INFORMATION

It is a state law that we receive medical and visual history each year from all patients as part of your eye exam. Thank you for your cooperation. Today's Date: _____

Name: _____ DOB: _____ SSN: _____

Primary Phone #: _____ Occupation: _____ Ins: _____

Please update the following if changed from last visit:

Address: _____ Apt or Suite #: _____

City/State/Zip: _____

OCULAR HISTORY

Chief Complaint: _____

Last Eye Exam: _____ Previous eye surgeries: _____

Check the following that apply (self):

- ☐ Cataracts
- ☐ Blindness
- ☐ Eye Strain
- ☐ Discharge
- ☐ Double vision
- ☐ Flashes/Floaters
- ☐ Glaucoma
- ☐ Headaches
- ☐ Lazy Eye or Eye Turn
- ☐ Macular Degeneration
- ☐ Pain
- ☐ Redness

PERSONAL HISTORY

Check the following that apply (self):

- ☐ Asthma
- ☐ Diabetes
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Pregnant
- ☐ Nursing
- ☐ Thyroid
- ☐ Smoking
- ☐ Alcohol
- ☐ Drugs

Please list medications you are currently taking: _____

Please list any drug allergies: _____

FAMILY HISTORY

Please specify family member:

- ☐ Blindness _____
- ☐ Diabetes _____
- ☐ Glaucoma _____
- ☐ Heart Condition _____
- ☐ High Blood Pressure _____
- ☐ Lazy Eye or Eye Turn _____
- ☐ Macular Degeneration _____
- ☐ Thyroid _____