GALLATIN VALLEY

VISION

Patient Information

Name: _____ Phone: _____

Address: _____ Email: _____

City, State: _____ Emergency Contact: _____

Zip: _____ Emergency Phone: _____

Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____ Sex: **M** or **F** Married: **Y** or **N**

Employer/School: _____ Occupation: _____

Hobbies: _____

Whom may we thank for referring you? _____

Medical Insurance: _____ Vision Insurance: _____

Medical History

Last Eye Exam: _____ Do you wear glasses? **Y or N** Do you wear contacts? **Y** or **N**

Are you Pregnant/ Nursing? _____ Alcohol Use? _____ Tobacco Use? _____

Please check only the conditions that apply to you or a member of your immediate family on a regular basis:

	Self	Family		Self	Family
Diabetes			Thyroid Problems		
High Cholesterol			Cancer		
High Blood Pressure			AIDS/ HIV		
Heart Problems			Glaucoma *		
Breathing Problems			Macular Degeneration*		
Arthritis			Hepatitis (Type ____)		
Headaches			Cataracts		
Head/Eye Injury			Depression/Anxiety		
Retinal Detachment			Crossed Eyes		
Eye Surgery			Blindness		
Lazy Eye			Flashes/Floaters		
Eye Strain			Eye Infection		
Double Vision			Dry Eyes		
Itchy Eyes			Light Sensitivity		
Watery Eyes			Temporary Vision Loss		
Blurred Vision			Red Eyes		

Medications:

_____

_____

_____

_____

DRUG ALLERGIES:

_____

_____

_____

_____

Other:

_____

_____

_____

_____

**See other side ⇨