CRAWFORD & WELTMER FAMILY EYE CARE

PERSONAL AND MEDICAL BACKGROUND

01. Primary Language?_____
02. Race?_____
03. Check one. ☐ Hispanic ☐ Not Hispanic

☐ Check here to opt out of answering the above questions.

01. What is the reason for your visit today?

_____
_____
_____
_____

02. Are you experiencing any of the following? Check all that apply.

☐ Burning ☐ Aching
☐ Watering ☐ Itching
☐ Dry Eyes

03. Would you like a contact lens exam today?*

☐ Yes ☐ No

If you check no, you will not have an active contact lens prescription and you will not be able to purchase contacts. Additional fees apply.

04. What do you wear?

☐ Contacts ☐ Glasses ☐ N/A

05. If glasses, did we make your current glasses?

☐ Yes ☐ No ☐ N/A

06. Current Medications:

_____
_____
_____

07. Allergies (Drug allergies, environmental allergies, latex sensitivity, etc.):

_____
_____

08. Have you ever had any serious injuries or illness to your eyes or head?

☐ Yes ☐ No

If yes, please explain: _____
_____
_____

09. Smoker?

☐ Yes amount/day _____
☐ No Have you ever been? _____

10. Alcohol?

☐ Yes amount/day _____
☐ No

Current Medical Conditions

☐ Cancer	☐ Arthritis	☐ Macular Degeneration
☐ Migraines	☐ Osteoarthritis	☐ Retinal Detachment
☐ Heart Disease	☐ Thyroid	☐ Cataracts
☐ High Blood Pressure	☐ Diabetes Type I	OTHER
☐ High Cholesterol	☐ Diabetes Type II	_____
☐ Stroke	☐ Allergies	_____
☐ Pregnant	☐ Glaucoma	_____

Continued on back

Has any family member (parent, sibling, children) had...	If yes, who? If no, please leave blank.
Cancer?	
Diabetes Type I?	
Diabetes Type II?	
High Blood Pressure?	
Hyperthyroidism?	
Hypothyroidism?	
Stroke?	
Cataracts?	
Mac. Degeneration?	
Glaucoma?	
Retinal Detachment?	
Other:	

What is your current occupation?

_____

What sports or recreational activities are you involved in?

_____

_____

_____

_____

Patient's Name in Print

_____ _____

Signature of Patient/Responsible Party Date