Walnutport Family Eyecare **Wind Gap Family Eyecare**

Name:_____ Date of Birth:_____
SSN:_____
Employer/School& Grade :_____ Occupation:_____
Medications:: (**If you have a list, bring it to the front desk**) _____

_____
Allergies to Medications:_____ Other Allergies:_____

Email for patient portal:_____
Are you Diabetic? □Yes □No If yes, Who is your Diabetic doctor?_____
Last blood sugar #:_____ A1C:_____
Are you pregnant or nursing? □Yes □No Diabetic Dr's Location? _____
Do you have High Blood Pressure? □Yes □ No Do you have High Cholesterol □Yes □ No
Do you have a Heart Condition? □Yes □ No Any other Medical Problems? Explain :_____
Do you use Tobacco? □ Yes □ No Do you use alcohol? □ Yes □ No
Have you had your COVID-19 vaccine? □ Yes □ No
Height: _____ Weight:_____ If applicable, last blood pressure reading: _____
Who is your primary care physician?_____Location: _____

Was your last eye exam here? □ Yes □ No If no, when was it? _____
Are you having any problems with your eyes? □Yes □No Explain:_____
Are you getting new glasses today? □Yes □No Are you updating your contact lenses? □ Yes □ No

Emergency Contact:
Name:_____Phone:_____Relationship_____