Walnutport Family Eyecare **W Gap Family Eyecare**

Name:_____ SS#_____

Date of Birth:_____ Male/ Female Race:_____

Workplace/School:_____ Occupation/Grade:_____

How did you hear about our office?_____

Last eye exam:_____ Where?:_____

Medications:_____

Allergies to medications:_____Other allergies:_____

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? _____

Have you had your COVID-19 vaccine? Yes / No Email for patient portal:_____

Height: _____ Weight:_____ If applicable, last blood pressure reading: _____

Who is your primary care physician?_____Location: _____

Emergency Contact: Name:_____Phone:_____Relationship_____

Do you currently wear glasses? Yes / No Do you want new glasses today? Yes / No
Do you currently wear Contacts? Yes / No (Brand/strength?)_____
Do you need an updated contact lens exam to order more contacts? Yes / No

Do you struggle with your vision? Distance Near Both None

PATIENT HISTORY	**NO**	**YES**		**NO**	**YES**
Glaucoma	○	○	Eye Allergies	○	○
Cataracts	○	○	Headaches	○	○
Cataract Surgery	○	○	Floaters	○	○
Detached Retina	○	○	Flashes of light	○	○
Macular Degeneration	○	○	Light Sensitivity	○	○
High Cholesterol	○	○	Pain or irritation	○	○ Ex:_____
High Blood Pressure	○	○	Dry Eye	○	○
Cancer	○	○	**SOCIAL HISTORY**		
Heart Condition	○	○	Do you use the following?		
Scaring on Eyes	○	○	Tobacco Products	○	○
Surgery to eyes	○	○	Alcohol	○	○

Other_____

FAMILY HISTORY	**NO**	**YES**	
Blindness	○	○	Relation:_____
Cataracts	○	○	Relation:_____
Glaucoma	○	○	Relation:_____
Macular Degen.	○	○	Relation:_____
Diabetes	○	○	Relation:_____
Gestational Diabetes	○	○	Relation:_____
High Blood Pressure	○	○	Relation:_____
Heart Disease	○	○	Relation:_____
Color Blindness	○	○	Relation:_____

Date Updated:_____

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