

Patient Information (Please Print)

Miss Mrs. Ms. Mr. Dr. (Please Circle) Email address _____
Last Name _____ First Name _____ MI _____ Male Female
Social Security Number _____ Needed for insurance _____ Married YES or NO
Address _____ Zip Code _____
Home Phone: _____ Business Phone: _____ Cell: _____
DOB ____/____/____ Occupation _____ Employer _____
Emergency Contact _____ Phone #: _____
Date of last exam _____ Dilated? YES / NO Referred By: _____
Have you seen Dr Blahnik before? YES NO
Vision Insurance _____ Medical Insurance _____

Medical Information

Vitals Height _____ Weight _____
What is your general health _____ ARE YOU PREGNANT YES OR NO

Do you have problems with any of these systems? (Please circle yes or no)

Gastrointestinal	Yes/No	Nervous	Yes/No	Endocrine(glands)	Yes/No
Ears/Nose/Throat	Yes/No	Urinary	Yes/No	Blood/Lym/cholesterol	Yes/No
Cardiovascular	Yes/No	Muscles/Bones	Yes/No	Allergic/Immunologic	Yes/No
Respiratory	Yes/No	Integumentary(skin)	Yes/No	Headaches	Yes/No
High Blood Pressure	Yes/No	Thyroid	Yes/No	Mental	Yes/No

Please explain any yes above _____

Diabetes Yes/No Type _____ Date of Diagnosis _____
Allergies to Medication Yes/No Which? _____ Reaction _____

Current Medications:

Name of family doctor _____

Family History

High Blood Pressure	Yes/No Relation _____	Macular Degeneration	Yes/No Relation _____
Diabetes	Yes/No Relation _____	Retinal Detachment	Yes/No Relation _____
Glaucoma	Yes/No Relation _____	Cataracts	Yes/No Relation _____
Cancer	Yes/No Relation _____		

Personal Eye Information

Do you have any eye conditions or problems? Yes/No What Kind? _____

Have you had any eye operations? Yes/No Type _____ Date _____

Do you have Glaucoma Yes/No Drops using for Glaucoma _____

Cataracts Yes/No Dry Eyes Yes/No Macular Degeneration Yes/No

Retinal Detachment Yes/No Blurred Vision Yes/No

Do you wear glasses? Yes/No Contact Lenses Yes/No Type _____

Additional Information _____

Social History:

Y N Do you drink alcohol? How many drinks per day? _____

Y N Do you smoke? Every Day _____ Some Day _____ Cigarettes or Cigars

Y N Have you ever smoked before? If yes when did you quit _____

Demographics:

____ African American ____ American Indian ____ Arab ____ Caucasian
____ Hawaiian ____ Hispanic/Latino ____ Indian ____ Indian ____ Multi Racial

Preferred Language; ____ English ____ Other, please specify _____

I understand that many examinations will require dilation of the pupil of the eye, which may make my driving vision blurry and light sensitive, and my transportation is my responsibility.

Signature _____ Date: ____/____/____

SEE ADDITIONAL PAGES PLEASE