**Patient Information**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date:\_\_\_\_/\_\_\_\_/\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SS#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Medical Dr:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Physical: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dr Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List of medications *and dosages* you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List medications you are allergic to:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe the allergic reaction you have:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Health Care Reform Act requires the following questions to be asked:**

Do you drink alcohol? Yes No Amount\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes, current smoker No, never Previous smoker Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you or your family members have any of the following? If yes, who?**

* Diabetes (Type 1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cataract \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Diabetes (Type 2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Degenerative disorder of macula \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hypertension \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Glaucoma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Hyperthyroidism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hypothyroidism \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dr. Lambaria will review your answers to the following? If yes, who?**

Last Exam \_\_\_\_/\_\_\_\_/\_\_\_\_\_ From Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age of glasses\_\_\_\_\_\_\_\_\_\_\_\_ Age of sunglasses\_\_\_\_\_\_\_\_\_

Do you participate in any of the following activities regularly?:

 Walking/Running Bicycling Golfing Fishing Motorcycle Shooting/Hunting Gardening Sewing Automotive

Do you spend 4 or more hours a day on a computer?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours a day do you spend using you cell phone/device?\_\_\_\_\_\_\_\_\_\_\_\_

How many hours a day do you spend reading/studying?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours do you spend driving and outdoors a week?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a current pair of sunglasses to protect your eyes? Yes No

Does glare bother you? Yes No If Yes: During the day? Yes No At night time? Yes No

Are you light sensitive? Yes No

Are you interested in contact lenses? Yes No

Have you been told you cannot wear contact lenses? Yes No

If you wear contacts, do you have a current pair of back up glasses? Yes No