VISION SOLUTIONS OPTOMETRY *Date:*

Name:	Sex: M F	**Preferred Language**: English Spanish Other:
Street:	City:	Zip:
Home Phone: ( ) Cell Phone: ( )	Birthdate: / /	Marital Status:
Email:	**How do you prefer to be contacted?** Cell work phone home phone email	
Occupation:	Wk Phone:	Employer:

Race
White Black/African American Asian
Hawaiian Native/Pacific Island. Amer. Indian/Alaskan Native

Ethnicity
Pac. Isl.
Hispanic

Social Security #:

Other family members who come to this office:

If you are a new patient, whom may we thank for referring you?

DO YOU SMOKE: Yes / No **WERE YOU A PRIOR SMOKER?** Yes / No

Do you have any problems with: **CARDIO:** Heart Disease High Blood Pressure High Cholesterol Stroke
ENDOCR: Diabetes type I Diabetes type 2 Thyroid **GI:** Hepatitis **HEAD:** Sinus **BLOOD/LYMPH** Anemia Leukemia
IMMUNE: Lupus HIV/AIDS Arthritis **INT EG:** Rosacea **MUSCLE:** Arthritis
NEURO: Dizziness MS Parkinson's disease Alzheimer's disease **RESPIRATORY** Asthma COPD
PSYCH: Autism Spectrum Depression/Anxiety
Pregnancy Cancer Other:
Please describe:

Have you had refractive surgery(LASIK or PRK)? Yes No Year:

Have you had any eye surgery or been treated for eye disease?

Please list all medications (prescribed, herbal and OTC):

List allergies to medications: