CLARITY
EYE CENTER
personalized eye care

Patient ID: _____
Date: _____

Patient Name _____ Date of Birth _____Age _____Gender ☐ M / ☐ F
Check One: ☐ Dr. ☐ Mrs. ☐ Ms. ☐ Mr.

Primary Doctor _____ Location _____
Previous Eye Doctor_____ Location _____
Specialist currently seeing _____ Location _____
Pharmacy Name _____ **Location** _____
List/give a copy of all medication currently taking _____
Are you allergic to any medications? ☐ Yes ☐ No Please list _____
What is the reason we are seeing you today? _____
Have you had serious eye problems or eye surgery in your past? ☐ Yes ☐ No
If yes please list _____
_____
List any other serious illness with approximate date's _____
_____
Other past surgeries _____
How did you hear about us?

- ☐ Doctor Referral if yes which Doctor? _____
- ☐ Friend/Family if yes please list? _____
- ☐ Advertisement which one? _____
- ☐ Other _____
- ☐ Website

Do you have any family history of the following?
☐ Glaucoma ☐ Stroke ☐ Hypertension ☐ Macular degeneration ☐ Diabetes ☐ High cholesterol
☐ Cataracts ☐ Cancer ☐ Vascular disease ☐ Retinal detachment ☐ Amblyopia (lazy eye)

Social History**:** Please answer the following: (Check one)
1. Received Flu Vaccine- ☐ YES / ☐ NO
2. Received Pneumococcal Vaccine- ☐ YES / ☐ NO
3. Smoking history- ☐ YES / ☐ NO (If yes how many pack per day) _____
4. Alcohol consumed- ☐ YES / ☐ NO (drinks per week) _____
5. Women- Are you pregnant? ☐ YES/ ☐ NO
6. Had a fall in the past year- ☐ YES / ☐ NO If yes how many?___Did it result in injury please explain? ☐ YES/ ☐ NO_____

Please mark those that apply to you:

☐ Cataract	☐ Hepatitis	☐ Depression	☐ Frequent cough
☐ Glaucoma	☐ Asthma	☐ Nose/throat problems	☐ Infectious disease
☐ Macular degeneration	☐ Anxiety	☐ Hard of hearing	☐ Muscular dystrophy
☐ Retinal detachment	☐ Arthritis	☐ Bronchitis	☐ Anemia or swollen gland
☐ Weight gain or loss	☐ Unexplained fever	☐ Skin disorder	☐ Injury to extremity
☐ Chest pain (angina)	☐ Elevated cholesterol	☐ Diabetes	☐ Parkinson's disease
☐ Frequent heartburn	☐ Colitis/ diverticulitis	☐ Tremors	☐ Multiple sclerosis
☐ Ulcer	☐ Sinusitis	☐ High blood pressure	☐ Autoimmune disorder
☐ Cancer	☐ Emphysema	☐ Shortness of breath	☐ Migraines/headaches
☐ Stroke	☐ Heart attack	☐ Hay Fever	☐ Kidney disease-dialysis
☐ Unexplained fatigue	☐ HIV/AIDS	☐ Eczema, hives	☐ Psychiatric illness.
☐ Irregular heart beat	☐ Enlarged prostate	☐ Congestive heart failure	Please list _____

Any other medical problems not listed? (If yes please list) _____

Contact Lenses: If currently wearing contact lenses, please indicate the following:
Check one- ☐ Hard/ ☐ Soft/ ☐ Daily wear/ ☐ Extended wear
Prescription information:_____

Are you interested in Botox or Fillers? Check one: ☐ Yes/ ☐ No/ ☐ Maybe.
Are you interested in LASIK? Check one: ☐ Yes/ ☐ No/ ☐ Maybe. Your hobbies/special visual needs? _____