

# Welcome to C.R. Lait Optical and Eye Associates

**PATIENT'S NAME:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
 Email: \_\_\_\_\_ DOB: \_\_\_\_\_ Age : \_\_\_\_\_ Sex: M / F  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Parent's name (if child): \_\_\_\_\_  
 Social Security Number: (for insurance purposes) \_\_\_\_\_  
 Name of Vision Insurance: \_\_\_\_\_ Medical Ins: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Date of Last Eye Exam: \_\_\_\_\_ Date of Last Physical: \_\_\_\_\_  
 Name of Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical History:** Do you or anyone in your immediate family have the following?

	You	Family		You	Family
Diabetes	___	___	Cancer	___	___
Hepatitis	___	___	Respiratory Problems	___	___
Migraines	___	___	High Blood Pressure	___	___
HIV/AIDS	___	___	Sickle Cell Anemia	___	___
Stroke	___	___	High Cholesterol	___	___
Thyroid Disease	___	___	Arthritis	___	___
Heart Disease	___	___	Retinal Disease	___	___
Glaucoma	___	___	Cataracts	___	___
Herpes	___	___	Dry Eyes	___	___
Lazy Eye	___	___	Macular Degeneration	___	___

If you are diabetic, when were you diagnosed? \_\_\_\_\_ Last blood sugar level? \_\_\_\_\_

Describe any previous injury, surgery, or infection to your eyes \_\_\_\_\_

Please list any medications you are taking including non-prescription, eye drops, and vitamins. \_\_\_\_\_

Do you have any drug allergies? yes / no If yes, please list: \_\_\_\_\_  
 Do you have any seasonal/environmental allergies? yes / no

**Social History:**

Do you drink alcohol?  no  occasional  1 per day  2-3 per day  4+ per day  
 Do you use tobacco?  no  occasional  1/2 pk/day  1 pk/day  1+ pk/ day

**FOR OFFICE USE ONLY:**

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_  
 Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_