Amarillo Vision Specialist, P.A.
Patient History Form

Name:_____ D.O.B:_____ Date:_____
Address:_____ City,St:_____ Zip:_____
Home Phone:_____ Cell:_____ Work Phone:_____
Employer/Occupation:_____
Insurance:_____

Visual and Medical History

Date of last exam:_____ By Whom:_____
Reason for today's exam:_____
Do you wear glasses? Yes / No Do you wear contacts? Yes / No
Contact Lens Type:_____
Who is your family doctor?_____ Last medical Exam:_____

(Please check any condition that applies to yourself of any members of your immediate family)

	Self	Family		Self	Family
Diabetes	___	___	Retinal Detachment	___	___
High Blood Pressure	___	___	Eye Surgery	___	___
Cataracts	___	___	Lazy/Crossed Eye	___	___
Heart Problems	___	___	Double Vision	___	___
Respiratory Problems	___	___	Blindness	___	___
Thyroid Problems	___	___	Head/Eye Injury	___	___
Glaucoma	___	___	Macular Degeneration	___	___

Please list any other medical problems:_____
Medications you are currently taking:_____
_____
What allergies do you have:_____
Are you pregnant or nursing?_____
Do you use tobacco products? Yes / No
Do you have any infectious diseases such as but not limited to HIV/AIDS, Hepatitis, Tuberculosis, Gonorrhea or Syphilis?_____