Gene O. Teigen, O.D.

EYEDENTITY
EYECARE + EYEWEAR

Grant W. Hardan, O.D.

Patient Name: _____ Date of Birth:_____

Ethnicity: ____Hispanic or Latino ____ NOT Hispanic or Latino Race: _____

Height: _____ Weight _____ Gender (circle one): M / F Date of last complete physical:_____

Current Primary Care Physician (PCP): _____Phone Number:_____

Current Pharmacy: _____Pharmacy Phone Number: _____

Do you wear Glasses?_____ Contact Lenses?_____ Sunglasses?_____ Date of last vision exam:_____

CURRENT MEDICATIONS (If more space is needed please attach an additional sheet of paper)	
Do you take medication for: ___Blood Pressure ___Cholesterol ___Diabetes ___Heart Disease ___Thyroid ___Allergies	
Name of Current Medications (brand or generic) (Include Ocular, Birth Control, OTC, vitamins, supplements, herbal)	**Reason for Medication – Comments**
LIST ANY MEDICATION ALLERGIES:	

HEALTH HISTORY (check all that apply)		
Medical Condition :	**Personal :**	**Family:**
Diabetes		
High Blood Pressure		
Heart Disease		
Cancer - _____		
Asthma		
Seizures		
Neurological disease		
Head Injuries		
Lupus		
Thyroid Disorder		
Migraine Headaches		
Sinus Disorder		
Other (list)_____		

CHECK IF APPLICABLE	
Headaches	
Blurred vision	
Eye Redness	
Dry Eyes	
Excess Tearing	
Light Sensitive	
Outdoor Glare	
Gritty Eyes	
Eye Infections	
Eye Strain	
Floaters	
Flashes	
Double Vision	

EYE HISTORY (check all that apply)		
Vision/Eye Condition:	**Personal :**	**Family:**
Eye Injury		
Glaucoma		
Retinal Detachment		
Macular Degeneration		
Eye Turn (In / Out)		
Amblyopia (Lazy Eye)		
Dry Eyes		
Watery Eyes		
Iritis		
Floaters		
Cataracts		
Color Blindness		
Other (list)_____		

SURGICAL HISTORY (Ocular and Systemic)			
Previous Surgery/Year:	1.	2.	3.

SOCIAL HISTORY
Do you use tobacco products? (Circle one) Current Former Never **How much / how often?**_____
Do you drink alcohol? (Mark one) _____ Never _____ Socially _____Daily (1 to 2 drinks) _____Daily (above average)
Do you use illegal drugs? (Circle one) YES / NO **Have you been exposed to/infected with:** ____ HIV ____Hepatitis

I certify that the above information is true and accurate to the best of my knowledge. I will notify this office of any changes in my medical status.

Signature: _____ **Date:** _____