Dr. Andrea Thau · Dr. Fran Reinstein · Dr. Marilyn Vricella

77 Park Avenue New York, NY 10016

Name: ____________________ Who can we thank for referring you? ____________

Date of Birth: ____________ Height: ____ Weight: _____ Last Flu Immunization: ______

Current medication(s) (incl. birth control/herbal): ______________________________

____

Allergies to medications ______________________________

Date of last Physical Exam: ____________ Primary Care Physician: ____________

Date of last EYE Exam: ____________ Name of Dr. and/or Facility: ____________

Do you wear glasses? Y / N If so, what kind? Distance/ Near

Do you wear contact lenses? Y / N What type? ____________ Do you sleep in them? Y / N

Is your distance vision (corrected) clear? Y / N Is your near vision (corrected) clear? Y / N

Do you have any of the following?

Flashes of light	y / n
Floaters or spots in front of your eyes	y / n
Loss of Vision	y / n
Eye Strain	y / n
Blurry Vision	y / n
Double Vision	y / n
Frequent headaches	y / n
Eye pain	y / n
Any eye injury or surgery	y / n
Lazy eye/ amblyopia	y / n
Burning, itching, redness, discharge	y / n
Eyes turn in or out	y / n

Family History (Does anyone have):

Glaucoma	y / n
Blindness/ other eye problems	y / n
High blood pressure/ heart problems	y / n
Diabetes	y / n
Any other medical condition	y / n

Medical Hx- Do you/have you ever had?

Allergies y / n If yes, please list: ______

____

Surgery/ hospitalization	y / n
Cardiovascular (heart)	y / n
Breathing problems	y / n
Gastrointestinal problems	y / n
Endocrine (diabetes, thyroid, etc.)	y / n
Urinary problems	y / n
Musculoskeletal problems	y / n
Neurological (high fever, seizures, etc)	y / n
Unexplained weight loss or gain	y / n
Ear/ Nose/ Throat problems	y / n
Blood diseases (i.e. sickle cell)	y / n
Cancer, HIV virus, other	y / n
Smoke	y / n
Drink alcohol	y / n

Patient Signature: ________________ **Date:** ________ **Reviewed by:** ________________**,OD**