PERSONAL & HEALTH INFORMATION

Name _____ Date_____

Preferred Language ___ English ___ Spanish ___ Other (list) _____

Ethnicity (federal definition) ___ Hispanic or Latino ___ Not Hispanic or Latino

Race (federal definition) ___American Indian ___ Asian ___ Black or Afro American
___Native Hawaiian or Other Pacific Islander ___ White

Primary Care Doctor _____ Address_____

Height_____ Weight _____ Blood Pressure(if known)_____

Do you smoke? ___ yes ___ no

List Medications or provide a list_____
_____

List Eyedrops _____

List any nutritional supplements/vitamins _____

Allergies/reactions to medications_____

Other Allergies_____

What is your primary reason for the visit today?_____

Do you currently wear contact lenses? ___Yes ___ No How long?_____

Type and brand of contacts?_____