Image Optical
Dr. Greg Proffitt

Name:_____ Age:_____ DOB:_____
Address:_____
City:_____ Zip:_____
Home:_____ Work:_____ Cell:_____
Occupation:_____ Employer:_____
E-Mail Address:_____

Medical History:

This history is privacy protected. If you feel uncomfortable answering any of the questions, you may discuss them directly with the Doctor.

Which medications(including over the counter) are you currently taking:_____
_____

Are you allergic to any medications: Yes No
If yes please list:_____
Do you have any general/seasonal allergies? Yes No
If yes please list:_____
List all Major illnesses, injuries, and/or surgeries:_____
_____

Ocular History:

Date of last exam:_____ Doctor:_____
Do you wear Eyeglasses?: Yes No Do you wear contact lenses?: Yes No
If so, which brand?:_____
Do you regularly sleep in your contacts?: Yes No
Which contact solution do you wear most often?:_____
Are you interested in LASIK surgery or any other refractive procedure?: Yes No
List all current eye diseases, injuries, or surgeries:_____

Family History:

Have you or your family members had/has any of the following health/eye problems?

Blindness	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Diabetes	Yes	No
Hypertension	Yes	No
Cancer	Yes	No
Heart Disease	Yes	No
Thyroid Disease	Yes	No
Arthritis	Yes	No
Stroke	Yes	No
Macular Degeneration	Yes	No

Other Hereditary Diseases:_____

Signature:_____Date:_____