Robertson Optical & Optometry
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NEW PATIENT FORM

NAME: _____

DATE OF BIRTH: _____ / _____ / _____
Year *Month* *Day*

OCULAR HISTORY

Please Indicate	*Provide details here*
How long ago was your last eye exam?	
Are you under the care of a specialist (Opthamologist)? ☐Y ☐N	
Any previous eye trauma or surgery? ☐Y ☐N	
Do you wear glasses? ☐Y ☐N	
Do you wear contact lenses? ☐Y ☐N	

MEDICAL HISTORY

Please Indicate	*Provide details here*
Any medical condition such as: ☐Y ☐N *For example: Diabetes? Hypertension? High Cholesterol? Thyroid? Migraines? Concussion? etc.*	
Do you smoke? ☐Y ☐N	
Any seasonal or drug allergies? ☐Y ☐N	
Are you currently pregnant or nursing? ☐Y ☐N	
Current medications? *Please list all*	

FAMILY HISTORY

Please Indicate	*Provide details here*
Diabetes ☐Y ☐N	
Heart disease or Stroke ☐Y ☐N	
Autoimmune disease or MS ☐Y ☐N *Rheumatoid Arthritis? Lupus? Grave's Disease? Type 1 Diabetes? Myasthenia Gravis? Vasculitis? etc.*	
Any ocular condition such as: *Glaucoma? Macular Degeneration? Lazy Eye? Keratoconus? etc.*	

Additional information you wish to provide: