Robertson Optical & Optometry
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PATIENT INFORMATION 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: *For example: Diabetes? Hypertension? High Cholesterol? Thyroid? Migraines? Concussion? etc.*	Y	N	
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 *Rheumatoid Arthritis? Lupus? Grave's Disease? Type 1 Diabetes? Myasthenia Gravis? Vasculitis? etc.*	Y	N	
Any ocular condition such as: *Glaucoma? Macular Degeneration? Lazy Eye? Keratoconus? etc.*			

Additional information you wish to provide: