Welcome to the office of Dr. James Tickner!

Name:_____ M / F Age:_____Date: _____

Address:_____ City/State:_____ Zip:_____

Home Phone:_____ Work Phone: _____ DOB:_____

Email: _____ Cell Phone: _____

Marital Status Please Circle One: Married Widowed Divorced Other

Employer/ Occupation : _____

Vision Plan Name:_____Medical Plan Name:_____

Visual and Medical History

Reason for Today's Exam: _____

Do you wear Glasses? Y N Do you work on a computer? Y N

Do you wear contact lenses? Y N Are you interested in contact lenses today? Y N

Medical Doctor/ City: _____ Last Exam: _____

Date of Last Eye Exam: _____ By Whom? _____

Please check any condition that applies to yourself or your immediate family (parent, sibling, child):

	Self	Family (Who)?		Self	Family (Who)?
Diabetes	_____	_____	Cataracts	_____	_____
High Blood Pressure	_____	_____	Glaucoma	_____	_____
Thyroid Problems	_____	_____	Retinal Detachment	_____	_____
Lung Disease	_____	_____	Blindness	_____	_____
Cancer	_____	_____	Macular Degeneration	_____	_____
Heart Disease	_____	_____	Lazy Eye	_____	_____
Elevated Cholesterol	_____	_____	Eye Injury or Surgery	_____	_____

Do you smoke? Y / N How Much? _____ Other Conditions:

Do you drink alcohol? Y / N How Much? _____

Females: Are you pregnant or is there a chance you may be pregnant today? Y N

Are you breastfeeding at this time? Y N

Please Circle Y or N: Do you notice any of the following becoming <u>frequent, significant or severe recently?</u>

Flashes of Light	Y	N	Headaches	Y	N	Tearing/ Discharge	Y	N
Floaters	Y	N	Double Vision	Y	N	Itching	Y	N
Blackout/ Loss of Vision	Y	N	Pain in or aroundeyes	Y	N	Dry/ Scratchy Eyes	Y	N

Medications:

List all medications you take:_____

_____

Do you have any allergies to medication? ( ) no ( ) yes. If yes then explain:_____

_____