SKYVISION™
CENTERS

Patient Name____ **Date of Birth** ____/____/_____

Email____ **Phone Number**_________________________

Social Security #_________________________ **Primary Care Physician**_____________________________

Pharmacy:
Name: ____
Phone Number: ____
Address: ____

Medications: (Please list all current medications with dosage)

Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:
Name:	Dosage:

Allergies: (Please list all allergies)
____
____

Social History:

Cigarette Smoking:
- ❑ Never Smoked
- ❑ Quit: Former Smoker
- ❑Smoke less than 1 pack per day
- ❑Smoke more than 1 pack per day

Alcohol:
- ❑Never Drinks
- ❑Occasional Drinks
- ❑1-2 Drinks per day
- ❑More than 3 Drinks per day

Race: ❑White ❑Asian ❑Black ❑ Hawaiian ❑American Indian ❑Unknown

Ethnicity: ❑Hispanic Origin ❑Non-Hispanic ❑Type Unknown

Language:____

Past Medical History: (Please Circle All That Apply)

Anxiety	Coronary Artery Disease	Hypertension	Pacemaker
Arthritis	Depression	HIV/AIDS	Prostate Cancer
Asthma	Diabetes:	Hypercholesterolemia	Radiation Treatment
Atrial Fibrillation	Type:	Hyperthyroidism	Seizures
Bone Marrow Transplant	End Stage Renal Disease	Hypothyroidism	Stroke
Breast Cancer	GERD	Leukemia	Valve Replacement
Colon Cancer	Hearing Loss	Lung Cancer	Other:
COPD	Hepatitis	Lymphoma	

Please list any past medical surgeries, including joint replacement and type:

____

____

Do you wear glasses or contacts? ____

Have you ever had any previous injuries, surgery, or diagnosis *in relation to your eyes*?

____

Family History: (Please circle all that apply) **M= Mother F=Father B=Brother S=Sister**

Blindness	M F B S	Diabetes	M F B S	Strabismus	M F B S
Cancer	M F B S	Glaucoma	M F B S	Macular Degeneration	M F B S
Cataracts	M F B S	Heart Disease	M F B S	Retinal Detachment	M F B S
CVA	M F B S	Migraine	M F B S	Other:	M F B S

Are you currently experiencing any of the following? (Please check yes or no)

Symptom	Yes	No	Symptom	Yes	No
Poor Vision			Arthritis		
Eye Pain			Headache		
Tearing			Seizure		
Redness			Stroke		
Jaw Pain			Paralysis		
Scalp Tenderness			Anxiety		
Loss of vision			Depression		
Dry Mouth			Diabetes		
High Blood Pressure			Thyroid Abnormalities		
Rapid Heart Beat			Bleeding		
Shortness of breath			Anemia		
Joint Pain			Allergies		
Stiffness			Hay Fever		

Alerts:

Are you currently experiencing any of the following? (Please check yes or no)

Alert	Yes	No
Allergy to Adhesive		
Allergy to Lidocaine		
Artificial Heart Valve		
Artificial Joints within the past two years		
Blood Thinners		
Defibrillator		
Flomax		
Narrow Angles		
Pacemaker		
Pregnancy or planning a pregnancy		
Steroid Responder		