TAYLOR
EYECARE

PERSONAL INFORMATION

Full Name
AS LISTED ON YOUR HEALTH INSURANCE CARD :

Date Of Birth : / / **Gender** : ☐ Male ☐ Female

Address :

Phone Number : **E-Mail** :

Work Number : **Social Security Number** :

Status : ☐ Single ☐ Married ☐ Divorce ☐ Other

Occupation : **Medical Doctor** :

Do you wear glasses? Y N **Do you wear contact lenses?** Y N

Have you had any eye surgeries? :

Do you smoke? Y N **Do you drink alcohol?** Y N **If yes how many drinks per week?**

Do you use recreational drugs? Y N

MEDICATIONS **Please include dosage. If needed, please attach medication list**

Eye Drops :

Medications :

Preferred Pharmacy :

Medication allergies :

HEALTH CONDITIONS **Please circle (Y) for yes and identify any problem you have in line provided**

- **Cardiovascular** (heart, blood pressure, etc) Y N
- **Endocrine** (diabetes, thyroid, etc) Y N
- **Gastrointestinal** (ulcers, acid reflux, etc) Y N
- **Genitourinary** (bladder, prostate, etc) Y N
- **Head** (ear, nose, throat, etc) Y N
- **Hematologic** (blood disorder, etc) Y N
- **Integumentary** (skin, etc) Y N
- **Muscles, Bones, Joints** (arthritis, lupus, etc) Y N
- **Neurological** (multiple sclerosis, etc) Y N
- **Psychiatric** (anxiety, depression, etc) Y N
- **Respiratory** (asthma, bronchitis, etc) Y N