Mullins Vision

Last Name:_____ First Name:_____ MI:_____
Address:_____City:_____State:_____ Zip:_____
Telephone: (Cell)_____ (Home)_____(Work)_____

Email:_____

Communication Preference (circle one): TEXT EMAIL PHONE

Marital Status (circle one): Married Divorced Single Widowed

SSN:_____ DOB:_____/_____/_____ GENDER: M / F

Occupation:_____ Employer:_____

Emergency Contact/Telephone Number:_____

Date of Last eye exam:_____ Today's Date:_____/_____/_____

Medical Information

Do you have problems with any of these systems? (Please circle all that apply)

Allergic /Immunologic	Y/N	Integumentary(skin)	Y/N	Mental	Y/N
Blood/Lymphatic	Y/N	Endocrine(glands)	Y/N	Musculoskeletal	Y/N
Cardiovascular	Y/N	Gastrointestinal	Y/N	Nervous	Y/N
Ears/Nose/Throat	Y/N	Genitourinary	Y/N	Respiratory	Y/N

Please Explain: _____

_____

Please answer all that apply:

Diabetes Y/N Type:_____ Date of Diagnosis:_____
Allergies Y/N Allergic to what?_____ Type of Reaction?_____
Current Medications:_____
Have you had any operations? Y/N What Type:_____
Do you use alcohol? Y/N Amount:_____
Do you use other substances? Y/N Type/Amount:_____
Name of family doctor?_____

Family History: Please answer if any of your family members have these problems.

High Blood Pressure	Y/N	Relation_____	Macular Degeneration	Y/N	Relation_____
Diabetes	Y/N	Relation_____	Retinal Detachment	Y/N	Relation_____
Glaucoma	Y/N	Relation_____	Cataracts	Y/N	Relation_____
Other eye conditions	Y/N	Relation_____			

Personal Eye Information

Have you had any eye operations? Y/N Type:_____ Date:_____
Have you had an eye injury? Y/N Type:_____ Date:_____
Do you have glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurry Vision? Y/N
Other eye problems? Type:_____
Do you wear glasses? Y/N Contact Lenses? Y/N Type/Brand:_____
Additional Information:_____
How did you hear about our office? Patient:_____ INTERNET COMMERCIAL OTHER:_____

Optometric Physician's Initials (To be completed by doctor):_____

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Height:_____inches

Weight:_____lbs

Blood Pressure(If known):_____/_____mmHg

Smoking Status:

- ☐ **Never Smoked**
- ☐ **Former Smoker. When did you stop smoking? _____yrs.**
- ☐ **Current Smoker. Amount per day?:_____**
  How long have you smoked?_____yrs.
- ☐ **Smokeless Tobacco User**

_____ _____

Printed Name Date