

LIFETIME VISION CARE, LLC

Date: _____

Name: _____

Occupation: _____

E-mail: _____

Preferred Language: English/ Spanish/ Other _____

Race: Caucasian/ Hispanic-Latino/ Other _____

Ethnicity: Non-Hispanic / Hispanic-Latino

Family Doctor: _____

Pharmacy Preference: _____

Reason For Visit: _____

CHECK THE FOLLOWING CONDITIONS THAT APPLY TO YOU (previous or current):

	Yes	No		Yes	No
<u>General</u>			<u>Gastrointestinal (digestive)</u>		
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ear/ Nose/ Throat</u>			Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Condition	<input type="checkbox"/>	<input type="checkbox"/>	<u>Musculoskeletal</u>		
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<u>Neurologic</u>			Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<u>Integumentary (skin)</u>		
Tumor	<input type="checkbox"/>	<input type="checkbox"/>	Rosacea	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Shingles (zoster)	<input type="checkbox"/>	<input type="checkbox"/>
Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>
Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>
<u>Psychologic</u>			Cold sores (simplex)	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<u>Endocrinology</u>		
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Type 1 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Type 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<u>Cardiovascular</u>			Thyroid Condition	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hormone Disorder	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<u>Blood Disorders</u>		
Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
<u>Respiratory</u>			High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<u>Allergic Conditions</u>		
Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Sjogren's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Females Only: Are you currently pregnant or nursing? YES NO

LIST CURRENT MEDICATIONS:

LIST MEDICATION ALLERGIES: **LATEX ALLERGY?** YES NO

Do YOU have (or have you previously had) any of the following eye conditions:

Cataract; Glaucoma; Macular degeneration; Other: _____

Surgery: Cataract; Glaucoma; Lasik Other: _____

Are you a smoker? YES NO Former Smoker

Do you drink alcohol? YES NO

Height: _____ / Weight: _____

(For Staff Use)		
Blood Pressure	Pulse	Date
____/____	____	____/____/____
____/____	____	____/____/____
____/____	____	____/____/____
____/____	____	____/____/____

