Jasper Eye Associates

First, Last, Preferred name: ______________________________

Date of birth: ____________________ **Male or Female**

Street Address: ______________________________

City, State, Zip: ______________________________

Email: ______________________________

Phone number: ______________________________

May we send you a text about upcoming appointments/eyewear orders?

YES **NO**

Social Secruitiy number (last four): ____________________

Employer: ____________________

Occupation: ____________________

Marital Status: married single divorced widowed

Race, Language: ______________________________

Emergency Contact: ______________________________

Patient History Information

Name:______________________________

Date of Last Eye Exam:_________________________

Do you currently wear glasses? YES NO

Do you currently wear contacts? YES NO

Have you or a family member experienced, or been treated for any of the following? Circle all that apply.

Cataracts: yes no family

Glaucoma: yes no family

LASIK or RK: yes no family

Macular Degeneration: yes no family

Retinal Detachment: yes no family

Are you currently experiencing, or have experienced, any of the following? Circle all that apply.

Double Vision Excess Tearing/Watering Floaters or Spots

Light Flashes Light Sensitivity

Have YOU ever been treated for any of the following? Circle all that apply.

AIDS/HIV Arthritis Asthma Blood/Lymph Disorder Cancer: Type?

Diabetes Heart Disease High Blood Pressure High Cholesterol Lupus

Neurological Conditions Seizures Stroke Thyroid Dysfunction

CURRENT MEDICATIONS (prescription and over-the-counter)

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Medication Drug Allergies (if any) _________________________