

# *Jasper Eye Associates*

Patient Name: \_\_\_\_\_  
First, Last Preferred

**Male or Female**

Date of Birth: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email address: \_\_\_\_\_

Phone number: \_\_\_\_\_

**May we text you about upcoming appointments and eyewear orders?**

**YES**

**NO**

Social Security number (last four): \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Race/Language: \_\_\_\_\_

Emergency Contact info: \_\_\_\_\_

# Medical History Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Date: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_ Date of last exam: \_\_\_\_\_

Currently Wear Glasses? YES or NO

Currently Wear Contacts? YES or NO Brand you currently wear: \_\_\_\_\_

Currently see an eye specialist? YES or NO

If yes, list practice/doctor name: \_\_\_\_\_

Please list any Ocular Surgeries with dates:

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

Glaucoma:	<b>Self</b> Mother Father Grandmother Grandfather
Retinal Detachment	<b>Self</b> Mother Father Grandmother Grandfather
Macular Degeneration	<b>Self</b> Mother Father Grandmother Grandfather

Have you ever been diagnosed or treated for any of the following? Please Check all that apply,

AIDS/HIV	<input type="checkbox"/>	Lupus	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Seizure	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Stroke	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	Blood/Lymph Disorder	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	Neurological Conditions	<input type="checkbox"/>

Current Medications (

Prescription / Over the Counter):

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Medication Allergies:

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