Clear Vision Begins with Healthy Eyes

Dr. Cary A. Kazdan & Associates, PLLC

Independent Licensed Optometrists

Please Check the Spelling of your Name and Address **Carefully**

SS# _____ **if over 18**

Home Phone # _____ or not available

Work Phone # _____ or not available

E-Mail address _____ or not available

****Cell Phone #** _____ or not available

If first time here, how did you get our name: _____ , If from someone, **Who:** _____

If first time here, Approx, when was your last exam **Date** _____ and **Location** _____

Current Occupation _____ **Hobbies** _____

List **ALL** medications you currently take (prescription **and** over-the-counter) **If you have a list, have front desk copy it**

_____

_____

Do you have **allergies** to any medications? Y / N (if yes, please list) _____

List all Major **illnesses** or **Injuries** _____

_____

List any Major **surgeries** you have had _____

_____

Do you smoke? No Yes If yes how much? _____/day For how long? _____years

Do you drink alcohol? No Yes If yes how much? - Seldom - Occasionally - Daily

If you do not wear **contacts** would you like to try them? Y N

Do your Eyes, currently have problems in any of the following areas?

Blurred vision	Y / N	Floaters	Y / N
Dryness/burning	Y / N	Flashing Lights	Y / N
Redness	Y / N	Sandy/gritty feeling	Y / N
Itching	Y / N	Cataracts	Y / N
Crossed or lazy eye	Y / N	Glare/light sensitivity	Y / N
Allergy issues	Y / N	Mucus discharge	Y / N
Eyestrain (computer or reading)	Y / N		

Extra Dr Notes

Problems in any of the following areas?	Y	N	Explanation of Problem
Ears, Nose, Throat (sinus, cough, dry mouth, etc.			
Cardiovascular **(Heart attack, High Blood Pressure, Stroke)**			
Respiratory (asthma, emphysema, etc)			
Gastrointestinal (stomach ulcers, intestinal, etc)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (**Arthritis**, etc)			
Skin (acne, warts, skin cancer, etc)			
Neurological (**Multiple Sclerosis**, etc)			
Blood, Lymph (high cholesterol, anemia, etc)			
Allergic, Immunologic (hay fever, lupus, etc)			
Endocrine (**Diabetes**, thyroid, etc) Under control? Y N Somewhat Diagnosed _____yr?			
Possibility of Pregnancy?			Discuss with Dr?

Family History: (parents, siblings, grandparents)

Blindness Y / N Glaucoma Y / N Cataracts Y / N

Macular Degeneration Y / N Diabetes Y / N Other _____

_____ Date_____

Dr's Signature (Dr. Cary A Kazdan) * (Dr. Peter J Micca)