

BENNETT OPTOMETRY

Please circle one: Ms. Miss Mrs. Mr. Dr. PhD

NAME: _____

DATE: _____

Flex Spending Account: YES NO

General Health Information Sheet

Primary Care Physician: _____ Phone #: _____

Please list any medications: _____

Please list any allergies (medical & general): _____

Do any of the following conditions / diseases apply to you:

- | | | |
|--|--|--|
| <input type="checkbox"/> Constitutional (fever, weight change) | <input type="checkbox"/> Heart condition/disease | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Ear/Nose/Mouth/Throat | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Psychological | <input type="checkbox"/> Lazy eye or eye turn |
| <input type="checkbox"/> Stomach or GI | <input type="checkbox"/> Cancer history | <input type="checkbox"/> Macular Degeneration |
| <input type="checkbox"/> Kidney or Liver | <input type="checkbox"/> Blood | <input type="checkbox"/> Retinal detachment |
| <input type="checkbox"/> Lung or Respiratory | <input type="checkbox"/> Sarcoid | <input type="checkbox"/> Dry eye |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Immune Deficiency |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis or joint | <input type="checkbox"/> Tobacco use <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Alcohol use <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy |
| <input type="checkbox"/> Pregnant | | <input type="checkbox"/> Drug use <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy |

If you indicated any of the above conditions apply to you, please explain and list treatment.

Please list any other health conditions.

Does your family history include any of the following? If yes, what is their relationship to you?

- | <input checked="" type="checkbox"/> | Relationship: | <input checked="" type="checkbox"/> | Relationship: |
|---|---------------|--|---------------|
| <input type="checkbox"/> Glaucoma | _____ | <input type="checkbox"/> High Blood Pressure | _____ |
| <input type="checkbox"/> Macular Degeneration | _____ | <input type="checkbox"/> Heart Disease | _____ |
| <input type="checkbox"/> Cataracts | _____ | <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Blindness | _____ | <input type="checkbox"/> Thyroid Condition | _____ |
| <input type="checkbox"/> Retinal Detachment | _____ | <input type="checkbox"/> Other | _____ |

Occupation, Hobbies, Special Vision Needs: _____

Computer use: Yes No How many hours per day?: _____ I use computer glasses: Yes No

Who may we thank for referring you: _____
Name of Doctor, Friend, Family, Insurance Co., Advertisement or Other

Signature _____

Date _____