Dr. Dawn Langford **Dr. Tyler Hanson**
Dr. Jason Langford **Dr. William Kusek**
Dr. Christa Hunnicutt **Dr. Emily Laub**

Patient Information

Patient Name____________________ Date of Birth__________

Home Address________________ City__________ State___ Zip Code______

Patient's Social Security # ____________ Email Address ________________ Sex___

Cell Phone (used for appointment reminders)____________ Home Phone____________

Primary Language__________ Ethnicity____________ Race____________

Special Needs____________ Occupation____________ Employer____________

Responsible Party (if different)________________ **Relationship to Patient**__________

Phone____________ Billing Address (if different)____________________

General Health History (Circle all that apply and describe)

Seasonal Allergies	Hypertension	Arthritis
High Cholesterol	Heart Disease __________	Cancer__________
Thyroid Disease________	Autoimmune Disorder________	Blood Disorder________
Psychiatric Disorder______	Neurological Disorder________	Respiratory Disorder______

Diabetes (Year of Diagnosis)_____ Type I Type II Use Insulin? Yes No

Other Health Issues____________________________

List Major Surgeries and dates________________________

Smoking Status: Never Smoker Former Smoker Occasional Every Day Years smoked______

Primary Doctor____________________ Date of last exam__________

Medications (Please include a printed list if you need more space)

____________ ____________ ____________

____________ ____________ ____________

Allergies to Medications________________________

Eye and Vision History (Circle all that apply) **Date of Last Eye Exam**________ **Location**________

Glaucoma	Cataracts	Keratoconus	Lazy eye	Macular degeneration
Eye Injury	Eye Infection	Eye Surgery	Floaters	Retinal Detachment
Eye Allergies	Dry Eye	Shingles of Face/Eye	Pterygium	Diabetic Retinopathy

Eye Surgery History (Include dates)____________________

Other Eye Problems (Please specify)____________________

Hobbies________________ Number of hours at a computer each day______

Do you wear glasses? Yes No Date of last prescription______ Use: Full Time / Distance / Near / Computer

Do you wear contacts? Yes No Date of last prescription______ Type/Brand____________

Family History (including parents, grandparents, siblings, children. Circle all that apply)

Glaucoma	Relationship________	Keratoconus	Relationship________
Cataracts	Relationship________	Blindness	Relationship________
Macular Degeneration	Relationship________	Other eye conditions	Relationship________