**Welcome to Pepelea Family Eye Care!** We are glad you are here. If you could please answer the following questions. This allows us to better care for you.

Name: last _____ first _____ middle initial____
Nickname _____

Cell number: _____
Home number: _____ *include area code
Work number: _____
Which is the preferred contact number? Home or Cell (circle home or cell)
Email address: _____
Date of Birth: _____
Place of employment:
_____

What is the reason for your visit?
_____
When was your last eye exam? _____ By whom? _____

Any history of surgery, disease, or infection to your eyes?
_____

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Do you wear glasses? _____ If yes, how old are your glasses? _____
When do you wear your glasses (for distance/ reading only/ computer)?
_____
Full time or Part time wear? _____
Do you wear Contacts? _____ How often? _____
What brand? _____
How often do you change them? _____
Brand of solution? _____
How many hours a day do you wear them? _____
Do you sleep in them? _____ How many nights in a row? _____
Do you swim with your contacts in? _____Do you swim regularly? _____

Any family history of eye diseases such as glaucoma, macular degeneration, cataracts, retinal detachments, crossed/lazy eye, or blindness?

_____

Do you have any medical problems? (just put a check or an X on the line)
General Health _____
Ear Nose Throat ____
Cardiovascular/heart ____
Respiratory ____
Genital/Kidney/Bladder ____
Muscle/Joint Bones ____
Gastro-intestinal ___
Skin ____
Neurological (Headaches, Migraines, Multiple Sclerosis, Seizures) _____
Psychiatric ____
Endocrine (Diabetes) ____
Blood/Lymph ____
Allergic/Immunologic ___
Cancer ____
List of medications, vitamins and over the counter drugs: include how often taken and dosage

_____
_____
_____
_____
_____
_____

List Allergies (including drug allergies):

_____
_____

Does the patient's Parents, Grandparents or siblings have any of the following:
Diabetes? _____
High blood pressure? _____
High cholesterol? _____
Heart disease? _____
Thyroid Disease_____
Cancer? _____
Any diseases not mentioned above please list?_____
Do You smoke or chew tobacco? **Yes or no** If yes, how long? _____
If you are a former smoker, for how long? _____ what year did you quit? _____
Occupation?_____
Hobbies _____