Young Eye Institute
4214 SW Lee Boulevard
Lawton, OK 73505
800-228-4214

Patient Name: _____

Date of Birth: _____ ☐ **Male** ☐ **Female**

Please complete the following and bring with you to your appointment. (Black ink only please)

HISTORY

FAMILY HISTORY:

Significant Family Hx: NO ☐ YES ☐

_____

SOCIAL HISTORY:

Smoking: ____ packs/day x _____ NO ☐

Alcohol: ____ drinks/day x _____ ☐

MEDICAL HISTORY:

	NO	YES	EXPLAIN:
Heart Disease/HTN	☐	☐	_____
Heart Attack/Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Neuro	☐	☐	_____
Lung	☐	☐	_____
GI	☐	☐	_____
Bones/Skin	☐	☐	_____
Other	☐	☐	_____

SURGICAL HISTORY:

_____ _____

_____ _____

_____ _____

CURRENT MEDICATIONS: (Please complete or bring printed list with you.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

ALLERGIES: _____

_____

Family Doctor: _____ **Optometrist:** NO ☐ YES ☐ _____

Other family members seen at our clinic: _____ **Date last seen:** _____

Referred by: _____

OTHER EYE HISTORY:

	NO	YES	
Glaucoma	☐	☐	_____
Retina	☐	☐	_____
Lazy Eye	☐	☐	_____
Other	☐	☐	_____

PREVIOUS EYE SURGERY: NO ☐ YES ☐ _____