Westheimer Vision Associates

Circle One: Mr. Mrs. Ms. Other: __________ Preferred Name:____________________ Today's Date: _______________

Name: ____________________________________ Date of Birth: ____________ SS#:_____________________ Sex: M F
First Initial Last

Address: ____ City: ________________ State: _______ Zip: __________

Home: ____________________________ Work: ____________________________ Cell: ____________________________

E-Mail: ____________________________________ Marital Status: S M Spouse's Name: ______________________

Occupation: _____________________________________ Employer: ____

Parent/Insurer: ____ SS#: ____

Are other members of your family patients here? Y N Their Names: ____

Whom may we thank for referring you to our office? ____

Personal Medical History

Please check those that apply

	Yourself	Family Member		Yourself	Family Member
Amblyopia (lazy eye)			Diabetes/Thyroid		
Cataracts			Ear, Nose, Throat		
Color Blind			Gastrointestinal		
Eye Injuries			High Blood Pressure		
Eye Infection			Heart Disease		
Eye Surgery			Kidney Disease		
Eye Turns In or Out			Muscles, Bones, Joints		
Glaucoma			Neurological/Psych		
Macular Degeneration			Other		
Retina Problems			Respiratory		
Allergies/Asthma			Skin		
Arthritis/Lupus			Stroke		
Cancer			Weight Loss		

Do You Smoke? Yes No **Do You Drink Alcohol?** None Occasionally Daily

General Health: ______________________________ **Drug Allergies:** ____

Medications: ____

Computer Use: None Occasionally Daily If daily, how many hours per day: __________________________

I acknowledge that I received the Notice of Privacy Practices from Westheimer Vision Associates.

Signature: ____ Date: _________________