Great Lakes Eyecare

Dr. James Bozic
Dr. Jenna Bayer

Patient Information

Last Name: _____ First Name: _____
Date of Birth: _____/_____/_____ Cell Number: (_____)_____
Occupation: _____ How did you hear about our office? _____
_____

Medical History

[ ] Diabetes Type 1 [ ] Type 2 [ ] [ ] High Blood Pressure [ ] High Cholesterol
[ ] Thyroid Conditions [ ] Seasonal Allergies [ ] Autoimmune Conditions

Other Medical Conditions:
_____

Current Medications:
_____

Medication Allergies:
_____

Primary Care Physician: _____ Date of Last General Exam: _____

Family Medical & Ocular History

[ ] Diabetes [ ] High Blood Pressure [ ] Macular Degeneration
[ ] Glaucoma [ ] Retinal Detachments

Ocular History

Date of Most Recent Eye Exam: _____ History of Eye Injury or Surgery: _____
_____ Date of Injury/Surgery: _____
Current Concerns About Your Vision or Eyes: _____
[ ] Blurry Vision [ ] Macular Degeneration [ ] Glaucoma [ ] Retinal Detachments
[ ] Cataracts [ ] Dry Eyes [ ] Lazy Eye

Vision Correction

Do you wear glasses? [ ] Yes [ ] No Age of Glasses: _____
Do you wear contact lenses? [ ] Yes [ ] No
Type of Lenses [ ] Daily [ ] Biweekly [ ] Monthly [ ] Hard/RGP
Do you sleep in your lenses? [ ] Yes [ ] No
Brand (if known): _____
Prescription (if known): _____

Pupil Dilation Consent

If necessary to complete today's exam, may we dilate your pupils? [Yes] [No]

Signature: _____ **Date:** _____