



**Dr. Cary A. Kazdan
& Associates, PLLC**
Independent Licensed Optometrists

Please Check the Spelling of your Name and Address **Carefully**

SS# _____ **if over 18**
 Home Phone # _____ or not available
 Work Phone # _____ or not available
 E-Mail address _____ or not available
 **Cell Phone # _____ or not available

If first time here, how did you get our name: _____, If from someone, **Who:** _____
If first time here, Approx, when was your last exam **Date** _____ and **Location** _____

Current Occupation _____ **Hobbies** _____

List **ALL** medications you currently take (prescription **and** over-the-counter) **If you have a list, have front desk copy it**

Do you have **allergies** to any medications? Y / N (if yes, please list) _____

List all Major **illnesses** or **Injuries** _____

List any Major **surgeries** you have had _____

Do you smoke? No Yes If yes how much? _____/day For how long? _____ years

Do you drink alcohol? No Yes If yes how much? - Seldom - Occasionally - Daily

If you do not wear **contacts** would you like to try them? Y N

Do your Eyes, currently have problems in any of the following areas?

Blurred vision	Y / N	Floaters	Y / N
Dryness/burning	Y / N	Flashing Lights	Y / N
Redness	Y / N	Sandy/gritty feeling	Y / N
Itching	Y / N	Cataracts	Y / N
Crossed or lazy eye	Y / N	Glare/light sensitivity	Y / N
Allergy issues	Y / N	Mucus discharge	Y / N
Eyestrain (computer or reading)	Y / N		

Extra Dr Notes

Problems in any of the following areas?	Y	N	Explanation of Problem
Ears, Nose, Throat (sinus, cough, dry mouth, etc.)			
Cardiovascular (Heart attack, High Blood Pressure, Stroke)			
Respiratory (asthma, emphysema, etc)			
Gastrointestinal (stomach ulcers, intestinal, etc)			
Genital, Kidney, Bladder			
Muscles, Bones, Joints (Arthritis , etc)			
Skin (acne, warts, skin cancer, etc)			
Neurological (Multiple Sclerosis , etc)			
Blood, Lymph (high cholesterol, anemia, etc)			
Allergic, Immunologic (hay fever, lupus, etc)			
Endocrine (Diabetes , thyroid, etc)			
Under control? Y N Somewhat Diagnosed _____yr?			
Possibility of Pregnancy?			Discuss with Dr?

Family History: (parents, siblings, grandparents)

Blindness Y / N Glaucoma Y / N Cataracts Y / N
 Macular Degeneration Y / N Diabetes Y / N Other _____

_____ Date _____
 Dr's Signature (Dr. Cary A Kazdan) * (Dr. Peter J Micca)