F. Mason Smith, O.D. ● Betsy W. Fraser, O.D. ● Diane G. See, O.D.
966 Houston Northcutt Blvd. Suite D. Mount Pleasant, S.C. 29464
843-881-2492

Name: ____ Email:____

Occupation: __________________________________ Primary Care Doctor:____

Do you have any hobbies?(boating, biking, running, scuba, sewing, reading, etc.)____

Please list any MEDICATIONS you take (include nutritional supplements and/or vitamins):__________________________________

____

Do you have ALLERGIC REACTIONS to any MEDICATIONS? Please list: ____

Personal Medical History: Please circle any of the systems you may have problems with or take medications for:

Respiratory (Asthma, COPD) | Cardiovascular (High Cholesterol, High Blood Pressure) | Headaches
Genital, Kidney, Bladder | Muscles, Bones, Joints (Arthritis) | Blood/Lymph
Skin (Acne, Warts, Skin Cancer) | Psychiatric (Anxiety, Depression) | Neurological (MS)
Gastrointestinal | Endocrine (Diabetes, Hypothyroid) | Ear, Nose, Throat
Immunologic | Allergies (Seasonal, Environmental) | Other___________

Personal Ocular History: Please circle if you have any of the following:

Amblyopic (Lazy Eye) | Blindness | Cataracts | Color Blindness
Strabismus (Eye Turn) | Macular Degeneration | Retinal Detachment | Glaucoma

Family Ocular and Medical History: Please circle and specify which family member:

Amblyopia (Lazy Eye) | Blindness | Cataracts | Color Blindness
Strabismus (Eye Turn) | Macular Degeneration | Retinal Detachment | Glaucoma
Diabetes | High Blood Pressure | Heart Disease | Cancer

Do you do any of the following? [ ] Smoke [ ] Drink Alcohol [ ] Use other substances

What is your current height? ____________________ What is your current weight? _________________________

Do you experience any of the following?

Blurred Vision (Distance/ Near) | Dry Eye | Watery Eyes | Floaters or Spots
Distorted Vision (Halos) | Double Vision | Other:_____________________________________

Do you wear any of the following? [ ] Glasses [ ] Contact Lenses [ ] Both

Are you interested in the following? [ ] Glasses [ ] Sunglasses [ ] Contact Lenses

What don't you like about your current glasses or contacts? ____

____

We participate in clinical training for optometric students. If you have any questions or concerns regarding this program, please let us know.

Payment is expected the date that services are rendered.

Please Sign: ____Date: ________________________________