ANDOVER OPTOMETRY ON CENTRAL
15 Central Street, Andover, MA 01810
(978) 475-5252, www.andoveroptometry.com

PATIENT INFORMATION

Name:	Date of Birth:

OCULAR HISTORY

Check all that apply:

☐ None
☐ Glaucoma ☐ Macular Degeneration ☐ Cataract ☐ Eye Turn ☐ Lazy Eye
☐ Injury:
☐ Surgery:
Other:

MEDICAL HISTORY

Primary Care Physician: ____ City/State: ______________________

Check all that apply:

☐ None

☐ ADD/ADHD	☐ Allergies	☐ Alzheimer’s Disease
☐ Angina	☐ Anxiety	☐ Arrhythmia
☐ Arthritis	☐ Asthma	☐ Atrial Fibrillation
☐ Cancer (type:_____________)	☐ Congestive Heart Failure	☐ COPD
☐ Coronary Artery Disease	☐ Crohn's Disease	☐ Depression
☐ Diabetes	☐ Eczema	☐ GERD/Heartburn
☐ Gout	☐ Heart Attack	☐ High Cholesterol
☐ Hypertension	☐ Insomnia/Sleeplessness	☐ Migraines
☐ Multiple Sclerosis	☐ Osteoporosis	☐ Parkinson’s Disease
☐ Prostate Enlargement	☐ Rosacea	☐ Seizures
☐ Sleep Apnea	☐ Stroke	☐ Thyroid Disease

Other:

MEDICATIONS:

Drug Name	Dosage
____	_______________________
____	_______________________
____	_______________________
____	_______________________
____	_______________________
____	_______________________

Patient name:

ALLERGIES to MEDICATIONS:

Drug Name	Reaction
____	______________________
____	______________________
____	______________________

SOCIAL HISTORY	
Smoking: ☐ Never ☐ Occasional ☐ Daily ☐ Former	**Alcohol:** ☐ No ☐ Yes _____ Drinks per week
Hobbies / Visual Needs:	
Computer work: ☐ No ☐ Yes: ________ hours per day	

FAMILY HISTORY
Check all that apply and list relatives who have the condition **Ocular:** ☐ Glaucoma: ____________________ ☐ Macular Degeneration: ____________________ ☐ Cataract: ____________________ ☐ Eye Turn: ____________________ ☐ Lazy Eye: ____________________ Other: ____________________
Medical: ☐ Diabetes: ____________________ ☐ Hypertension: ____________________ ☐ Heart disease: ____________________ ☐ Cancer: ____________________ Other: ____________________

Would you like to participate in a clinical study? ☐ Yes ☐ No