Dr. Muneer N. Hanna & Assoicates

Board Certified Optometric Physicians

Patient Name _____
Last First MI

Parent or Spouses Name _____

Address _____

City _____ State _____ Zip _____

Birthdate _____/_____/_____ Current Age _____

Occupation _____ Employer_____

Family members who are patients at our office _____

Today's Date _____/_____/_____

Male _____ Female_____

Soc. Sec. # _____/_____/_____

Home phone ( ) _____

Work Phone ( ) _____

Other phone ( ) _____

Email _____

Health Information

Reason for your visit

_____ Annual exam
_____ Eye Health Concern
_____ Contact Lens Evaluation
_____ Pre or Post Eye Surgery
_____ Interested in Discussing Refractive Eye Surgery or Contact Lens Options
_____ Emergency

Do you use a computer? Y N How many hours per day? _____

When was your last eye exam? _____

Previous Eye Doctor's Name _____

Current Primary Doctor's Name _____

Current Medications

Allergies

Have you ever had eye surgery or an eye injury? Y N
Explain:

Have you or any of your blood relatives ever had any of the following conditions?

Condition	Family Member
Diabetes	
High Blood Pressure	
Heart/Vascular Disease	
Thyroid Disorder	
Cancer/tumors	
Digestive Disorder	
Breathing Disorder	
Migraine Headaches	
Immune Deficiency	
Glaucoma	
Cataracts	
Lazy Eye	
Blindness	
Retinal Detachment	
Macular Degeneration	
Other	