Lee R. Moore, Jr., O.D.

311 Prospect Avenue ♦ Charles Town, WV 25414 ♦ 304.725.1411 ♦ Fax 304.725.1412

Last Name: _____ First Name: _____MI:_____ Male ___ Female___
Address_____
City: _____ State: _____ Zip: _____
Telephone:(W)_____ (H)_____
SSN: _____-_____-_____ Date of Birth: _____
Occupation: _____
Employer: _____
Emergency contact/ Telephone Number: _____
Date of last eye exam? _____ Dilated?_____ Today's date?_____

Medical Information:

Do you have problems with any of these systems? *(please circle all that apply)*

Gastrointestinal	Y/N	Nervous	Y/N	Mental	Y/N
Ear/Nose/Throat	Y/N	Genitourinary	Y/N	Endocrine (glands)	Y/N
Cardiovascular	Y/N	Musculoskeletal	Y/N	Blood/lymph	Y/N
Respiratory	Y/N	Integumentary (skin)	Y/N	Allergic/immunologic	Y/N

Please Explain: _____

Please answer all that apply:

Diabetes Y/N Type_____ Date of Diagnosis?_____

Current medication(s): _____

_____

Medication allergy Y/N What happens? _____

Other health problems:_____

Have you had any operations? Y/N Kind? _____
_____When?_____

Do you use cigarettes/tobacco?_____ Alcohol? _____Other substances?_____

Name of family doctor: _____ Date of last visit: _____

Date of last tetanus shot: _____

Family History:

High blood pressure: Y/N Relation? _____ Macular degeneration: Y/N Relation? _____

Diabetes: Y/N Relation? _____ Retinal detachment Y/N Relation? _____

Glaucoma Y/N Relation? _____ Cataracts Y/N Relation? _____

Other eye condition(s) Y/N What kind? _____ Relation? _____

Personal Eye Information:

Have you had any eye operations? Y/N Type: _____ Date: _____
Have you had an eye injury? Y/N Kind: _____ Date: _____
Do you have Glaucoma? Y/N Cataracts? Y/N Dry Eyes? Y/N Blurred Vision? Y/N Other? _____
Do you wear glasses? Y/N Contacts? Y/N Type? _____

Additional Information? _____