DR. JOSEPH T. MARRA
OPTOMETRISTS

Date _____

Last Name _____ First Name _____ MI_____

Social Security # _____ Spouse's Name _____

If a child, parent or guardian's name _____

Address _____

Date of birth _____ Referred by _____

The best telephone numbers to contact you during our normal business hours (9-5 M-F)?

☐ Home _____ ☐ Work _____

☐ Cell _____ ☐ Pager _____

Firm employed by _____ how many years? _____

Position and duties – i.e. job description, student, homemaker, etc _____

Describe your visual problems _____

Describe any pain or irritation to your eyes _____

Do you have headaches? _____ if so, how often? _____

List medical conditions _____ Medications _____

Name of family doctor _____

List allergies to medication _____

Have you ever had any disease or surgery of the eyes? _____

Do you family history of eye disease? _____

Do you have a family history of diabetes, high blood pressure, cancer, etc.? _____

Have you ever had an injury to your eyes or head? _____

Recreations and hobbies you engage in _____

Do you have unusual sensitivity to sunlight? _____ Do you smoke?_____

Please circle any problems you have recently experienced:

Loss of vision	Halos around lights	Mucous discharge
Blurred vision	Fluctuating vision	Redness
Loss of side vision	Dryness	Double vision
Excess tearing/watering	Distorted vision	Sandy gritty feeling
Floaters/flashes	Itching	Eye pain or soreness
Burning	Glare/light sensitivity	Foreign body sensation

Do you wear contact lenses? _____ Type and brand _____

Remarks/Additional Information: