Welcome to Eagle Vision & Eye Clinic, P.C.

Our practice is using electronic health records. We are collecting this data in an effort to improve patient care and create a complete patient record. We appreciate your assistance with providing your health information.

Required Information	***Please fill out completely and return to the Receptionist.**
Full Name	
Date of Birth	
Primary Care Physician	
Smoking Status	Please select your current smoking status (circle) : Current every day smoker Current some day smoker Former smoker - Please list date range you smoked _____to_____ Never smoked Smoker, current status unknown Unknown if ever smoked
Please list current medications or indicate that you filled out online or have an attached list.	
Please list any allergies or indicate that you filled out online.	
Your pharmacy and location	