Dr. Yachin Bao
281-491-2199

Title: ______ Suffix: ______ Gender: M F

Last Name: ________________ First Name: ________________ MI: ___

Address: ______________________ City, St, Zip ____________________

Home Phone: ___________________ Daytime : ______________________

Date of Birth: ___/___/___ SS: ____-____-_____ Email: ____________________

Occupation: ______________ Employer: _________________ Vision Ins. ______________

Last Eye Exam: ___/___/___ Name of Last Dr: ____________ Medical Ins. ______________

Have you worn contacts: Y N Interested in contacts: Y N Interested in Refractive Surgery: Y N

Reason for Visit ________________ How did you hear about our office ______________

Do you or anyone in your family have any HISTORY of the following:

High Blood Pressure	___ Self	___Family	Glaucoma	___ Self	___Family
Heart Condition	___ Self	___Family	Cataracts	___ Self	___Family
Diabetes	___ Self	___Family	Retinal Disease	___ Self	___Family
Thyroid	___ Self	___Family	Eye Injury	___ Self	___Family
Kidney	___ Self	___Family	Eye Infections	___ Self	___Family
Stabismus/Amblyopia	___ Self	___Family	Eye Surgery	___ Self	___Family

Other ____

Medications Currently Taking ____

Allergies ____

Emergency Contact Name/Relationship ______________________ Number ________________

Any Injury, Illness, or Previous Conditions _______________________________________