WELCOME TO OUR OFFICE!!

(Please Print)

TODAY'S DATE ____________________

Name ______________________________
First MI Last
Street ______________________________
City ______________ State ______ Zip ________
Home Phone ______________________________
Work Phone ______________________________
Social Security Number ______________________________
Date of Birth __________ Age ________ Sex M F
Email Address ______________________________
Employer (or School) ______________________________
Occupation (or Grade) ______________________________
Marital Status ______________________________
Spouse (or Parent's) Name ______________________________
Spouse (or Parent's) Work Phone ______________________________

Vision Insurance ______________________________
Subscriber's Name ______________________________
Relationship to Pt. ______________________________
Subscriber's DOB ______________________________
ID# ____________________ Group# __________
Secondary Insurance ______________________________
Subscriber's Name ______________________________
Relationship to Pt. ______________________________
Subscriber's DOB ______________________________
ID# ____________________ Group# __________

How did you hear about our office?
____

What is the purpose of your visit today?
____

Past Ocular History

Date of Last comprehensive eye examination ______________________________
Performed by whom? ______________________________
Do you have glasses? Y N
How old are your glasses? ______________________________
How often do you wear them ? ______________________________
Any problems with your glasses? ______________________________
How long have you been wearing glasses? ______________________________

Contact Lens Information

Have you ever worn/Do you wear contact lenses? Y N
If no, skip to Social/Occupational History.
If so, what kind (brand, measurements, color, etc.)? ______________________________
____
Fit by whom? ______________________________
Hours per day you wear your contact lenses? ______________________________
How often do you replace them? ______________________________
Which solutions do you use? ______________________________

Social/Occupational Information

Do you work on a computer? Y N How often? __________
Drive for long periods of time? Y N
Work or hobbies that require you to use your eyes extensively?
____

Medical History

Have you had/do currently have any problems with the following?

Eye Surgery	Y N	Flashes/Floaters/Spots	Y N
Eye Injury	Y N	Itchy, Burning, Dry Eyes	Y N
Eye Infection	Y N	Glare or Reflections	Y N
Lazy Eye	Y N	Cataracts	Y N
Glaucoma	Y N	Macular Degeneration	Y N
Frequent Headaches	Y N	High Blood Pressure	Y N
Diabetes	Y N	Blood/lymph Disorders	Y N
Heart Disease	Y N	Ear, Nose, Throat Disease	Y N
Cancer	Y N	Skin/Muscular Disorders	Y N
Thyroid Disease	Y N	Genitourinary Disorders	Y N
Allergies	Y N	Stomach/Intestine Disease	Y N
Mental Illness	Y N	Neurologic Disorders	Y N

Use of Tobacco Products Y N
Frequent Use of Alcohol Products Y N
History of Substance Abuse Y N
Other Medical Conditions: ______________________________
Drug Allergies Y N To what? ______________________________

List any Medications you are currently taking.
(Prescription or over the counter)

Medication Reason
____
____
____
____
____

Physicians Name ______________________________

Family Medical Information

Does any one in your immediate family have any of the following?

Blindness Y N from ? ______________
Glaucoma Y N Macular Degeneration Y N
Cataracts Y N Diabetes Y N
Other ______________________________