WELCOME TO OUR OFFICE!

Please fill out both sides of this form.

PATIENT INFORMATION

Name M /F

Address

City, State, Zip

Birthdate

Social Security Number

Phone Number

Work Phone

Cell Phone Text OK? Y/N

Email Address Email OK? Y/N

Employer or School

Occupation

□Minor □Single □Married □Seperated □Divorced □Widowed

RESPONSIBLE PARTY INFORMATION

Name

Address

City, State, Zip

Birthdate

Social Security Number

Employer

INSURANCE INFORMATION

Type of Insurance

Name of Insured

Birthdate of Insured

Whom may we thank for referring you?

EYE HISTORY

Date of Last Eye Exam _____

Ocular Medications/Drops _____

Ocular Surgery _____

Ocular Injuries _____

Please circle the following choices that pertain to you:

I currently wear glasses Yes No Occasionally Age of Glasses _____

I currently wear contacts Yes No Occasionally No, but I'm interested

Type of contacts Gas Perm Soft Extended Wear Dailies

Are they comfortable Yes No Occasionally Yes, but vision fluctuates

How often do you dispose of your contacts? _____

Hours of computer use per day: _____

Do *you* or any *family members* have the following conditions?

	Myself	Family Member	Relationship
Cataract	□	□	
Crossed Eyes	□	□	
Glaucoma	□	□	
Lazy Eye	□	□	
Macular Degeneration	□	□	
Retinal Detachment	□	□	
Retinal Disease	□	□	

Please indicate if you have noticed any of the following:

Dry Eyes	□	Flashes or Floaters	□
Itchy Eyes	□	Double Vision	□
Tired Eyes	□	Styes or Chalazions	□
Headaches	□	Difficult Night Driving	□
Glare or Light Sensitivity	□	Eye Pain or Soreness	□

Allergies to Medications & Reactions: None or _____

Current Medications (including over the counter medications, aspirin, oral contraceptives and home remedies)

_____

_____

_____

(over)

MEDICAL HISTORY

Last Medical Exam: _____ Medical Doctor: _____

Please list any previous Surgeries and/or Hospitalizations: _____

Please indicate if you are: ☐ Using Tobacco products Amount_____ Years_____ □ Pregnant

☐ Using Alcohol Amount per week_____ □ Nursing

Please indicate if you have any problems with the following systems and explain:

Allergy □ _____
(Environmental agents, medications, etc)

Cardiovascular □ _____
(High blood pressure, high cholesterol, stroke, heart attack, etc)

Constitutional □ _____
(Changes in weight, hunger, thirst, sickness, etc)

Endocrine □ _____
(Diabetes, thyroid problems, etc)

Gastrointestinal □ _____
(Acid reflux, IBS, etc)

Genitourinary □ _____
(Kidney stones, ovarian or prostate problems, etc)

Ears,Nose,Mouth,Throat □ _____
(Hearing loss, dry mouth, chronic cough, etc)

Hematologic/Lymphatic □ _____
(Anemia, sickle cell, blood disorders, etc)

Immunologic □ _____
(Sarcoidosis, Sjogren's, etc)

Integumentary/Skin □ _____
(Psoriasis, dermatitis, rosacea, etc)

Musculoskeletal □ _____
(Arthritis, fibromyalgia, osteoporosis, etc)

Neurologic □ _____
(Parkinson's disease, MS, seizures, etc)

Psychiatric □ _____
(Depression, anxiety, etc)

Respiratory □ _____
(Asthma, COPD, emphysema, etc)

NONE of the above □

List any ***family members*** with *systemic conditions* listed above: _____

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino

Race: □ American Indian □ Asian □ Black or African American □ Native Hawaiian/Other Pacific Islander □ Hispanic or Latino □ White

Preferred Language: □ English □ Spanish

During your examination:

**Do not worry about making a mistake, giving the wrong answer or if you feel your answers contradict themselves*

**Do not be alarmed if, for a few minutes during the examination, you feel your vision is getting worse instead of better*

_____ _____
Patient Signature (or Parent/Guardian) Date

_____ _____
Doctor Signature Date