



Welcome to Our Office

(Please Print)

Name _____ Today's Date _____

Please circle (Dr. Mr. Mrs. Ms. Miss)

Marital Status: single married widowed divorced

Mailing Address _____

City, State, Zip _____

Email Address: _____

Patient Date of Birth: _____ Sex: _____ M _____ F Age: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Social Security #: _____ Employer: _____

Occupation: _____ Full Time or Part Time

Name of Parent/Guardian (if patient under 18): _____

Guardian Date of Birth: _____ Guardian Social Security Number: _____

Please tell us about your insurance:

Name of Vision Insurance Company: _____

Name of Policy Holder: _____ DOB: _____

SSN of Policy Holder: _____

Address of Policy Holder if Different: _____

Name of Medical Insurance Company: _____

Name of Policy Holder: _____ DOB: _____

SSN of Policy Holder: _____

Address of Policy Holder if Different: _____

How did you first hear about our office?

- Yellow Pages Internet Saw in Building
 Community Event Insurance Associate Health Fair
 Friend/Relative... _____
 Physician... _____

It is our goal to provide our clientele the highest quality eye care and service. We are committed to excellence in meeting each patient's unique visual and eye health needs with the highest ethics and integrity.

History

What is the purpose of today's visit? _____

Date of Last Eye Exam _____ Name of Eye Doctor _____

Date of Last Physical Exam _____ Name of Physician _____

Do you experience..... (Check those that apply)

- | | | | | |
|---|---|--|---|--------------------------------------|
| <input type="checkbox"/> Blurry distance vision | <input type="checkbox"/> Objects floating in vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Watery Eyes |
| <input type="checkbox"/> Blurry near vision | <input type="checkbox"/> Flashes of light | <input type="checkbox"/> Pain/Pressure in Eyes | <input type="checkbox"/> Headaches | <input type="checkbox"/> Redness |
| <input type="checkbox"/> Burning/Dryness | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Other _____ | | |

Please list any Eye Surgeries or injuries you have had _____

MEDICAL HISTORY

Do YOU have a history of problems with:

Yes No (if yes please circle)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Eye- glaucoma, eye turn, macular degeneration, blindness, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergic/Immunologic- lupus, hay fever, rheumatoid arthritis, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiovascular- heart disease, high blood pressure, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | General/Constitutional- fever, weight loss or gain, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Endocrine- diabetes, thyroid, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Gastrointestinal- ulcers, intestinal disease, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Genital, Kidney and Bladder- infections, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Ear, Nose and Throat- sinus disorder, chronic cough, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Blood/Lymph- bleeding disorder, high cholesterol, anemia, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin- rosacea, skin cancer, psoriasis, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Musculoskeletal- arthritis, back pain, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurological- multiple sclerosis, stroke, seizures, migraine headaches, aneurysm, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychiatric- anxiety, depression, ADHD, schizophrenia, other _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Respiratory- asthma, emphysema, chronic cough, other _____ |

Please list ALL MEDICATIONS you are currently taking:

Are you ALLERGIC to any Medications? No YES, (please list) _____

Does anyone in your FAMILY have a history of the following conditions? (please check all that apply)

- | | | | | |
|---------------------------------------|---|---|---|------------------------------------|
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Retinal Detachment | <input type="checkbox"/> Amblyopia (lazy eye) | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke | <input type="checkbox"/> Other _____ | |

SOCIAL HISTORY

Do you use tobacco products? Yes No if yes, _____ packs/day

Do you drink alcohol? Yes No if yes, _____ drinks/day

(This information is important for medical purposes as well as compliance with insurance directives)

I have been offered a copy of the Notice of Privacy Practices.

Signature _____ (if patient under 18, parent or guardian signature required)

Thank you!