PATIENT INFORMATION: DATE_____

MR.____ MRS.____ MISS____ MS____ DR.____ FR____ RABI____

NAME: FIRST_____ MI____ LAST_____

ADDRESS_____CITY_____ST___ ZIP_____

HM PH# ( )_____WK PH# ( )_____CELL PH# ( )_____

EMAIL ADDRESS_____

S.S.#_____DATE OF BIRTH_____MARITAL STATUS_____

OCCUPATION_____EMPLOYER/SCHOOL_____

WHOM MAY WE THANK FOR REFERRING YOU?_____

IF THE PATIENT IS A MINOR PARENTS PLEASE FILL OUT THIS SECTION

MOTHER:

NAME:_____

ADDRESS_____

CITY_____ST____ZIP_____

PHONE ( )_____

S.S. #_____

DATE OF BIRTH_____

EMPLOYER_____

FATHER:

NAME:_____

ADDRESS_____

CITY_____ST____ZIP_____

PHONE ( )_____

S.S. #_____

DATE OF BIRTH_____

EMPLOYER_____

INSURANCE INFORMATION:

VISION INSURANCE_____

SUBSCRIBER NAME_____

MEDICAL INSURANCE_____

SUBSCRIBER NAME_____

EYE & VISION INFORMATION:

Is there a specific reason you decided to get your eyes checked?

_____

_____

DATE OF LAST EXAM_____PREVIOUS EYE DOCTOR_____ WERE YOU DILATED? Y/N

DO YOU WEAR GLASSES? Y/N

DO YOU WEAR CONTACT LENSES? Y/N (circle) Gas Permeable / Soft / Disposable / Toric / Bifocal / Other_____

ARE YOU INTERESTED IN LASER VISION CORRECTION? Y/N MAYBE

Do you currently experience any of the following? (check only if yes)

_____ Blur at Distance
_____ Blur at Near
_____ Trouble Seeing at Night
_____ Trouble with Glare
_____ Distortion
_____ Light Bothers Eyes
_____ See Floaters, Flashes
_____ Eye Pain / Ache
_____ Eyes Water
_____ Eyes Burn / Dry
_____ Eyes Red
_____ Eyes Matter/Discharge
_____ See Double
_____ Frequent Headaches

Do you have or had in the past....

_____ Eye Surgery_____
_____ Eye Injury, Abrasion, Foreign Body
_____ Turned, Crossed or Lazy Eye
_____ Glaucoma
_____ Cataracts
_____ Other Eye Problem_____
_____

Do you use eye drops (list)?_____ For_____

CONTINUED ON BACK

MEDICAL INFORMATION

Who is your health care physician?_____ Location:_____

Do you have or ever had any problems with any of the following systems (common conditions are given in parenthesis)? Please circle yes or no; list your specific condition(s), and list all medications in the space provided.

NO YES **Constitutional** (Fever, Weight Loss/Gain)_____
NO YES **Integumentary** (Skin Conditions, Acne, Rosacea)_____
NO YES **Neurological** (Seizures, Headache, Migraines)_____
NO YES **Endocrine** (Thyroid, Diabetes)_____
NO YES **Ears, Nose, Throat** (Sinus, Cough)_____
NO YES **Respiratory** (Asthma, Bronchitis)_____
NO YES **Cardiovascular** (Blood Pressure, Cholesterol, Heart, Stroke)_____
NO YES **Gastrointestinal** (Diarrhea, Constipation, Acid Reflux)_____
NO YES **Genitourinary** (STD's, Birth Control, Kidney, Bladder)_____
NO YES **Musculoskeletal** (Arthritis, Fibromyalgia)_____
NO YES **Lymphatic** (Anemia, Leukemia, Keyloid Scarring)_____
NO YES **Allergic** (List All Known Allergies or Hay Fever)_____
NO YES **Immunologic** (HIV)_____
NO YES **Psychiatric** (Depression, Anxiety)_____
NO YES Tobacco, Alcohol or Illegal Drug Use_____

Please list any other health conditions and all medications in the space below:

_____
_____
_____
_____

Are you **allergic** to any medications? (List):_____
Reaction? (What happens?)_____

FAMILY HISTORY

Does anyone in your family have any of the following conditions? State their relation to you.

NO YES Glaucoma:_____ NO YES Turned, Crossed, or Lazy Eye:_____
NO YES Cataracts:_____ NO YES Retinal Problems_____
NO YES Blindness/Macular Degen:_____ NO YES Diabetes:_____
NO YES Corneal Problems:_____ NO YES High Blood Pressure:_____

Patient Signature:_____ **Date:**_____

Doctor Signature:_____ **Date:**_____

Please Review Information Annually and Initial. Thank You

Date_____Patient____Dr.____ Date_____Patient____Dr.____
Date_____Patient____Dr.____ Date_____Patient____Dr.____
Date_____Patient____Dr.____ Date_____Patient____Dr.____
Date_____Patient____Dr.____ Date_____Patient____Dr.____
Date_____Patient____Dr.____ Date_____Patient____Dr.____