WELCOME TO OUR OFFICE

PLEASE COMPLETE THE FOLLOWING INFORMATION

Date _____ / _____ / _____

PATIENT IDENTIFYING INFORMATION

LAST NAME ☐ MR. ☐ MRS. ☐ MS. ☐ MISS ☐ DR.	FIRST NAME	MIDDLE	DATE OF BIRTH / /	AGE
HOME ADDRESS	APARTMENT P.O. BOX	CITY	STATE	ZIP
SOCIAL SECURITY NUMBER	HOME TELEPHONE ( )	OFFICE TELEPHONE ( )	MOBILE TELEPHONE ( )	
EMPLOYER (SCHOOL)	OCCUPATION / (GRADE)	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	GENDER ☐ MALE ☐ FEMALE	RACE / ETHNICITY
EMAIL ADDRESS		HOBBIES / LIFESTYLE		

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ INSURANCE	☐ LOCATION	☐ REFERRED BY FRIEND	WHOM MAY WE THANK FOR REFERRING YOU?
☐ GOOGLE	☐ WEBSITE	☐ REFERRED BY DOCTOR	

IF PATIENT IS UNDER 18 YEARS OR STUDENT

NAME OF PARENT / GUARDIAN	HOME TELEPHONE	WORK TELEPHONE	MOBILE TELEPHONE

EMERGENCY CONTACT

EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE - PRIMARY	TELEPHONE - MOBILE

MEDICAL INFORMATION

NAME OF **PRIMARY CARE PHYSICIAN**	DATE OF LAST **PHYSICAL** EXAM	NAME (PLACE) OF PREVIOUS **EYE** DR	DATE OF LAST **EYE** EXAM

MEDICAL INSURANCE COMPANY

NAME OF **MEDICAL INSURANCE** COMPANY	POLICY HOLDER NAME (EMPLOYEE)	POLICY HOLDER SOCIAL SECURITY #	RELATIONSHIP TO PATIENT
GROUP NAME	GROUP NUMBER	ID NUMBER	TELEPHONE NUMBER OF INSURANCE COMPANY

VISION INSURANCE COVERAGE

NAME OF INSURANCE COMPANY - **VISION COVERAGE**	GROUP NAME	GROUP NUMBER	INSURED IDENTIFICATION CARD #
NAME OF POLICY HOLDER MEMBER	MEMBER DATE OF BIRTH	MEMBER SOCIAL SECURITY NUMBER	INSURANCE COMPANY TELEPHONE NUMBER
RELATIONSHIP TO PATIENT	MEMBER EMPLOYER	MEMBER WORK TELEPHONE	MOBILE TELEPHONE

ABOUT YOUR EYE EXAMINATION

Several procedures are required to examine the health of your eyes and determine treatment and/or the prescription for your eyewear. The comprehensive examination generally requires the instillation of eye drops to ***dilate the pupil of the eye***. Dilating drops allow the doctor to examine the structures inside of the eye. These drops may result in ***light sensitivity, hazy vision*** and ***difficulty focusing at near***, for a duration of *four (4) to eight (8) hours*. Please exercise caution while driving, operating equipment, or reading during the duration of these effects.

☐ I acknowledge the importance of **dilating drops** and understand the effects on my vision. I wish to ☐ **ACCEPT** ☐ **DECLINE** the **DILATING EYE DROPS**

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

REASON FOR VISIT:

YES		YES	
☐	Annual Examination	☐	Contact Lens Fitting
☐	Eye Health Evaluation	☐	LASIK Consultation
☐	Pre-op or Post-op Care	☐	Diabetic Eye Exam
☐	Emergency, Injury, Trauma	☐	Dry Eye Evaluation
☐	Cataract Exam	☐	Glaucoma Evaluation
☐	Retinal Exam	☐	Other
☐	Date of your last eye exam?		
☐	Hours worked on computer?	____	# Hours per day
☐	Do you wear glasses?	☐	Distance or ☐ Near
☐	Do you wear contact lenses?		Brand?

ARE YOU IN INTERESTED IN?

☐ Contact Lenses?	CL Type?
☐ Color Contact Lenses?	Color?
☐ LASIK eye surgery?	When?

EYE SURGERY

	Date / Please Describe
☐ Cataract surgery	
☐ Eye muscle surgery	
☐ Retinal Surgery	
☐ Refractive surgery (LASIK)	
☐ Eye injury or Eye Trauma	
☐ Foreign Body Removal	
☐ Other	

SOCIAL HISTORY – SMOKING / ALCOHOL

☐ Never Smoker	☐ No Alcohol Consumption
☐ Current Smoker	☐ Social Alcohol Consumption
# _____ packs per day	# _____drinks per week
☐ Former Smoker	☐ Recreational Drugs

OCULAR HISTORY

Do you or any blood relatives have vision disorders?

☐ No Known Eye Conditions	YOU	FAMILY MEMBER / WHO
Amblyopia / Lazy eye	☐	☐
Blindness	☐	☐
Cataracts	☐	☐
Color blindness	☐	☐
Corneal Scars	☐	☐
Crossed / turned eyes	☐	☐
Diabetic Retinopathy	☐	☐
Dry Eyes	☐	☐
Glaucoma	☐	☐
Herpes Simplex Keratitis	☐	☐
Keratoconus	☐	☐
Macular degeneration	☐	☐
Retinal Detachment	☐	☐
Other Vision Disorder(s)	☐	☐

FEMALES (circle if relevant)

YES Pregnant **YES** Nursing

GENERAL CONSTITUTION

- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fatigue / Weakness

DO YOU EXPERIENCE?

YES		YES	
☐	Blurred vision	☐	Foreign body sensation
☐	Burning	☐	Glare / light sensitivity
☐	Distorted vision	☐	Eye or eyelid infection
☐	Double vision	☐	Itching
☐	Drooping eyelid	☐	Loss of vision
☐	Dry Eyes	☐	Night driving difficulty
☐	Excess tearing / Discharge	☐	Redness
☐	Eye pain or soreness	☐	Sandy or gritty feeling
☐	Flashes of light	☐	Tired eyes
☐	Floaters	☐	Uncomfortable glasses

PATIENT HEALTH SYSTEMS REVIEW

Do you or any blood relatives have health conditions?

☐ No Known Health Conditions	YOU	FAMILY MEMBER / WHO
Cardiovascular Disease		
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Endocrine Disorders		
Diabetes ☐ Type 1 ☐ Type 2	☐	☐
Hormonal Disorders	☐	☐
Thyroid Disease	☐	☐
Ears, Nose, Throat Disorders	☐	☐
Hearing Impairment	☐	☐
Cough / Cold / Infection / Sinusitis	☐	☐
Gastrointestinal Disease	☐	☐
Stomach / Intestinal Disorder	☐	☐
Hepatitis ___A ___B ___C	☐	☐
Urogenital Disease	☐	☐
Bladder / Urinary Disease	☐	☐
Menopause, Endometrioses	☐	☐
Sexually Transmitted Disease	☐	☐
Hematologic, Blood, Lymph	☐	☐
Anemia	☐	☐
Sickle Cell	☐	☐
Immunologic Disease	☐	☐
HIV Positive	☐	☐
Collagen Vascular, Lupus	☐	☐
Muscluloskeletal	☐	☐
Arthritis, Joint Pain	☐	☐
Fibromyalgia	☐	☐
Multiple Sclerosis	☐	☐
Neuro Headaches/Migraine	☐	☐
Dizziness / Vertigo	☐	☐
Seizures / Fainting	☐	☐
Psychiatric Disorders	☐	☐
Anxiety / Stress / Depression	☐	☐
Respiratory Asthma, Bronchitis,	☐	☐
COPD	☐	☐
Skin, Acne, Rosacea	☐	☐
Basil Cell, Skin Cancer	☐	☐
Eczema, Psoriasis, Dermatitis	☐	☐
Herpes / Zoster / Shingles	☐	☐

MEDICATION

List all medications and conditions treated
(include vitamins, recreational and over the counter drugs)

DOSAGE

☐ NONE

ALLERGIES

List all drug and food allergies
(include medications, food, tape, latex and dyes)

☐ NONE ☐ ENVIRONMENTAL ☐ SEASONAL