

WELCOME TO OUR OFFICE!

Patients Name: _____ Today's Date _____
 Male Female Birthdate: _____ Age: _____ Email: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Work Phone: _____ SSN: _____
 Marital Status: Married Single Other: _____ Full Time Student
 Employment Status: Employed Retired Other: _____ Employer: _____
 Name of person responsible for payment: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Method of payment: Check Cash Credit Card Insurance
 How did you hear about our office? Newspaper ad Drive by Other
 What type of work do you do? _____ Referral If referral, by whom: _____

Health History:

Reason for today's visit: _____

Approximate date of last eye exam: _____

Do you currently wear glasses? Yes No Full Time Distance Reading Only'

Age of Current glasses/Contacts: _____

How would you rate your health? Excellent Good Fair Poor

Are you currently taking any medications? Yes No If so, what? _____

Do you use cigarettes/tobacco? _____ Alcohol? _____ Other Substance(s)? _____

Do any of the following conditions apply to you?

- Drug Allergies - List _____ Allergies - List _____
 Epilepsy Sinus Trouble Frequent Headaches
 Pregnant Recently had children

Do you or anyone in your family have a history of the following? (Check all that apply)

	Self	Family	How related? (immediate family, I.E. parents, grandparents)
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had the following conditions involving you eyes?

	Yes	No		Yes	No		Yes	No
Eye Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Severe Pain	<input type="checkbox"/>	<input type="checkbox"/>	Eye Infection	<input type="checkbox"/>	<input type="checkbox"/>
Eye Injury	<input type="checkbox"/>	<input type="checkbox"/>	Floaters/Spots	<input type="checkbox"/>	<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	<input type="checkbox"/>
Medical Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to Light	<input type="checkbox"/>	<input type="checkbox"/>	Eye Strain	<input type="checkbox"/>	<input type="checkbox"/>
Poor Distant Vision	<input type="checkbox"/>	<input type="checkbox"/>	Poor Near Vision	<input type="checkbox"/>	<input type="checkbox"/>	Eyes Burn/Itch	<input type="checkbox"/>	<input type="checkbox"/>

Do you work at a computer or video terminal? Yes No

What hobbies or sports do you participate in? _____

Have you ever worn contact lenses before? Yes No

Are you interested in wearing contacts? Yes No

If yes, what style? Soft Extended Wear Gas Permeable Bifocal Astigmatic Tinted
 Disposable Unsure

Emergency Contact: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____