PATIENT NAME_____ DATE_____

ADDRESS_____

CITY/STATE/ZIP_____ EMAIL_____

CELLPHONE_____ TEXT Y/N 2# PHONE_____

PATIENT SS#_____ - _____ - _____ EMPLOYER_____ BIRTHDATE_____

PATIENT OR GUARDIAN_____ CONTACT#_____

PLEASE CIRCLE YES OR NO

VISUAL PROBLEMS

Y/N None, Yearly Exam
Y/N Distance Blurred
Y/N Near Blurred
Y/N Eyestrain
Y/N Light Sensitivity
Y/N Double Vision
Y/N Loss of Vision
Y/N Flashing Lights
Y/N Floaters/Spot
Y/N Headaches (Eyes)
Y/N Burning Eyes
Y/N Red Eyes
Y/N Itching Eyes
Y/N Dry Eyes
Y/N Injury to Eye(s)
Y/N Variable Vision
Y/N Twitching Lids

PATIENT'S HEALTH HISTORY

Y/N Cataracts ☐ R ☐ L
Y/N Glaucoma
Y/N Diabetes
Y/N High Blood Pressure
Y/N Heart Condition
Y/N Cancer=_____
Y/N Thyroid Condtion
Y/N Allergies
Y/N Hay Fever/Sinus
Y/N Migraines
Y/N Lazy Eye ☐ R ☐ L
Y/N Tobacco Use
Y/N Alcohol
Y/N Drug Use
Y/N Other Health Conditions= _____
_____

FAMILY HEALTH HISTORY

Y/N Glaucoma
Y/N Diabetes
Y/N High Blood Pressure
Y/N Heart Condition
Y/N Cancer
Y/N Cataracts
Y/N Allergies
Y/N Thyroid Condtion
Y/N Migraines
Y/N Blindness
Y/N Lazy Eye
Y/N Poor Color Vision
Y/N Turned Eye
Y/N Other Health Conditions

Do you do computer work? ❒ Yes ❒ No If yes, how many hours per day?_____

Are you presently taking any medications/drugs? ❒ Yes ❒ No
If yes what medications?_____

Are you allergic to any medications? ❒ Yes ❒ No If yes, what medications?_____

_____

Have you ever had any serious eye disease, injury or surgery? ❒ Yes ❒ No

If yes, please explain:_____

Do you, or have you ever worn contact lenses or glasses? ❒ Yes ❒ No
If yes, what type? ❒ Hard ❒ Soft ❒ Gas Permeable Hard ❒ Toric ❒ Glasses

When were you last examined?_____ By whom?_____

NAME OF INSURANCE_____ ID #/or SSN #_____
(Please show insurance cards to receptionist)

POLICY HOLDER_____ BIRTHDATE_____

NOTICE OF PRIVACY SIGNATURE_____