



Welcome to our office! It is our desire to provide you with the very best in vision care. We realize your time is valuable and our staff will attend to you as quickly as possible. In order for us to serve you better, we need certain biographical information from you. Please complete the following data for our records. (PLEASE PRINT)

Date: _____

PATIENT INFORMATION

Patient _____
Last name _____ First name _____ Initial _____ Prefer to be called _____
Address: _____ City: _____ State: _____ Zip: _____
Sex M F Marital Status: Married Single Other Race: _____
Birth date: _____ Social Security #: _____ Email address: _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer (or school) _____ Occupation(or grade): _____
Emergency Contact: _____ Phone: _____
Family members who are patients: _____
Whom may we thank for referring you to our office? _____

RESPONSIBLE PARTY (If under age 18)

Who is responsible for this account _____
Relationship to patient _____
Address(if different) _____ City _____ State _____ Zip _____
Employer _____ Work# _____

EYE HEALTH HISTORY

Date of last exam: _____ Doctor: _____ Dilated: Yes No
How many hours per day do you work on a computer? _____ Do you have any other specific visual demands? _____
Do you currently wear glasses? Yes No How old are your glasses? _____ Do you have prescription sunglasses? Yes No
Have you ever worn contacts? Yes No If no, Are you interested in wearing contact lenses? Yes No
Do you currently wear contacts? Yes No Are you interested in refractive surgery (Lasik)? Yes No
Describe any problems with your contact lenses: _____

Circle if you are experiencing any of the below:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Blurry distance vision | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Floaters | <input type="checkbox"/> Sudden loss of vision |
| <input type="checkbox"/> Blurry near vision | <input type="checkbox"/> Itchy Eyes | <input type="checkbox"/> Watery Eyes | <input type="checkbox"/> Dry Eyes |
| <input type="checkbox"/> Sensitivity to light | <input type="checkbox"/> Discharge | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Twitching Eyelid |
| <input type="checkbox"/> Flashing lights | <input type="checkbox"/> History of Styes | <input type="checkbox"/> Redness | <input type="checkbox"/> Poor night vision |

Ocular History:

- | | |
|---|--------------------------------------|
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Injury |
| <input type="checkbox"/> Crossed Eyes | <input type="checkbox"/> Eye Surgery |
| <input type="checkbox"/> Retinal Detachment | |

PLEASE FLIP OVER

MEDICAL HISTORY

Medical Insurance: _____

Primary Care Physician _____

Do you have allergies to medications? Yes No If yes, please list: _____

Do you have Diabetes? Yes No Date of first diagnosis: _____ Last blood sugar: _____

Do you have Hypertension? Yes No Is it controlled? Yes No

List any medications that you take: _____

List all major injuries, surgeries, and/or hospitalizations you have had:

Are you pregnant or nursing? Yes No

REVIEW OF SYSTEMS

Do you have any problems with any of the following body systems? (Please circle and explain)

Gastrointestinal _____ Nervous _____ Blood /Lymph _____

Ear/Nose/Throat _____ Urinary _____ Allergies _____

Cardiovascular _____ Muscles/Bones _____ Immunological _____

Respiratory _____ Headaches _____ Integumentary(skin) _____

High Blood Pressure _____ Endocrine(glands) _____ Mental _____

FAMILY HISTORY

Do you have any of the following that run in your immediate family? (Please circle and list relation)

High Blood Pressure _____ Diabetes _____ Heart Conditions _____

Cancer _____ Glaucoma _____ Macular Degeneration: _____

Lazy Eye _____ Blindness _____ Retinal detachment _____

SOCIAL HISTORY

Do you drive? Yes No

Do you use tobacco products? Yes No If yes, type/amount/how long? _____

Do you drink alcohol? Yes No If yes, type/amount/how long? _____

Do you use illegal drugs? Yes No If yes, type/amount/how long? _____

Have you been exposed to or infected with HIV Hepatitis

HIPPA NOTICE OF PRIVACY PRACTICES

I have read and understand the HIPPA Notice of Privacy Practices. _____(signature)

Please indicate if you want your medical history shared with anyone other than yourself _____

Dr's. Initials _____ Date _____